



User Manual

User Manual

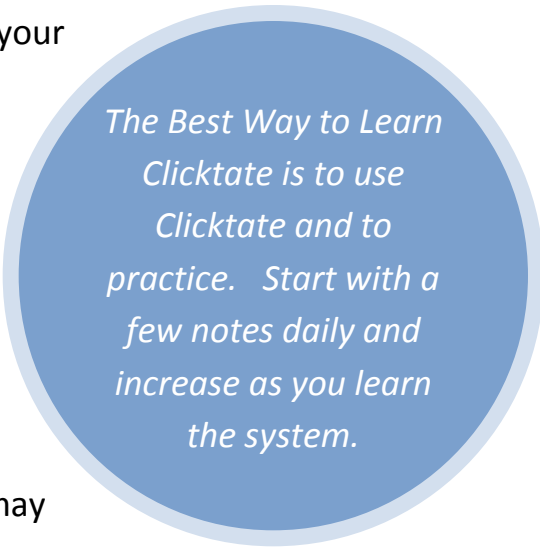
www.clicktate.com

Welcome to clicktate.com. With Clicktate, you will be able to quickly and inexpensively generate office notes, manage a physician schedule, save notes into patient folders, write electronic or paper prescriptions, develop user customized templates, and create multiple accounts for one practice with sharing of a common patient database within the group.

Since Clicktate does have a “learning curve” we encourage you to take a few moments and familiarize yourself with the system by reviewing this Users Manual. We also encourage you to take a few days (fourteen to be exact) during your free trial and get to know the system. During your **FREE NO OBLIGATION** trial you can create as many notes as you like, maintain a schedule, and send interoffice messages all at absolutely no expense to yourself or your practice.

We pride ourselves on being responsive to our users. Don’t hesitate to contact us anytime if you have questions or comments.

We may be reached at info@clicktate.com or you may call us at 1-888-8click8 (1-888-825-4258).



*The Best Way to Learn
Clicktate is to use
Clicktate and to
practice. Start with a
few notes daily and
increase as you learn
the system.*

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Section I: About LCD Solutions and Clicktate

Clicktate™ was released to the medical community in 2006 by LCD Solutions, Inc., a group dedicated to developing an inexpensive, intuitive and easily accessible system for medical documentation. Our goals were to develop a system that:

- the average provider could master in a short amount of time
- would create complete and accurate medical notes
- would save money, cut cost and provide revenue generating opportunities in the form of increased efficiency
- would improve the medical care received by patients

Since this time the user response to Clicktate™ has been overwhelmingly positive. Over the past five years of development, Clicktate™ has become more than just a “note writer” and now has become the Electronic Health Record of choice for many practices in nearly every state.

Our users will find that Clicktate is continually improving with many new features, many of which are user requested. During our design process, we take every effort to ensure that Clicktate™ remains user friendly and has the features necessary to allow a medical practice to function smoothly and efficiently. Before a new feature is put into Clicktate™ we make sure that it will accomplish three goals:

- Improve Practice Efficiency
- Improve Provider Productivity
- Improve Patient Care

In 2011, Clicktate™ made significant improvements including:

- ✓ Added additional modules including laboratory interfaces, reporting and document imaging
- ✓ Partnered strategically to provide a fully integrated practice management system including billing and coding
- ✓ Developed a Data exchange solution to allow true EMR to EMR communication and CCD documentation
- ✓ Achieved ONC-HIT certification to allow customers to achieve the full incentive available under the Medicare EHR Incentive Program

During your trial period, you will be contacted by a Clicktate™ representative in order to discuss further options and to schedule a demonstration and/or training webinar at no cost to yourself.

This manual will serve as a guide for new Clicktate™ users. It will also provide an oversight into new features found in Clicktate™ for our long term customers.

We will continue to be responsive to our customers, so we welcome feedback and suggestions. We may be contacted at 1-888-8click8 (1-888-825-4258) or via email at info@clicktate.com.

Our Mission Statement

Clicktate's mission is to lead the market in developing Electronic Health Record technologies that are easy to use, easy to learn, easy to implement and easy to afford. We strive to be a leader in the development of medical record technology that is complete, certified, and secure. We want to lead the market in innovation and assist medical providers in their efforts to provide better care to their patients. All the while, we will strive to keep our system so easy to use so that providers can't imagine using any other system.

Our Business Goals

Our goals are to add an additional 48 medical practices per year to our existing customer base by continuing innovation and development and striving to continue to be the easiest to use, implement, learn and afford EHR on the market.

Our Business Objectives

- ✓ Continue innovative development of Clicktate (Ongoing)
- ✓ Continue on-line advertising to continue to attract a strong customer base (Ongoing)
- ✓ Better follow-up of on-line trial sign-ups (Ongoing)
- ✓ Improved customer experience for trial sign-ups (1 Month)
- ✓ Continue our high level of customer satisfaction (Ongoing)
- ✓ Convert 10-20% of on-line sign-ups to clients (Ongoing)
- ✓ Hire 2-4 dedicated sales staff with regional responsibility utilizing a base salary + incentive payments for sales and ongoing usage (6 Months)
- ✓ Sales dinners/ demonstrations for providers in 4-6 large cities (1 Per Quarter)
- ✓ Monthly ads in a major medical journal (Start in 3 Months)
- ✓ Phase 2 Meaningful Use Certification (2013)

Our Values

Clicktate is committed to providing excellent service in an ethical, honest and customer based approach. If our customers aren't happy, we aren't happy and will do what it takes to rectify the situation in an honest and fair manner. In general, we will treat our customers the way that we want to be treated. Fairly. Ethically. Honestly.

Our Vision

To continue to promote the use of the Clicktate Electronic Health Record for the improvement of patient care and the provider experience in providing that patient care.

Section II: Configuring Your Browser

System Requirements

Clicktate is designed to work optimally with Internet Explorer versions 7, 8 and 9, Safari and Google Chrome. In addition, for full functionality, you will need Microsoft® Word, Adobe® Acrobat and Microsoft® Excel or comparable spreadsheet software on your computer.

Pop-Up Blockers

Clicktate relies on pop-ups to function properly, and they are an integral part of the ability to navigate through Clicktate. It is important to allow your browser to accept pop-ups from Clicktate.

One important note about Clicktate: It is important that you disable your pop-up blocker and allow pop-ups from Clicktate so that the system will function properly.

To configure the pop-up blocker to allow Clicktate to work, follow these steps:

Go to the TOOLS Dropdown menu at the top of the internet browser.



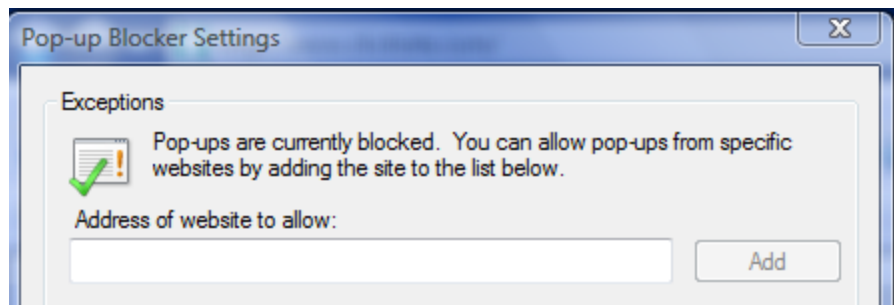
Open the TOOLS Menu.

Select Pop-up Blocker and choose one of the following options.

OPTION 1: Select Turn OFF Pop-up Blocker. This will completely disable the pop-up blocker and allow all pop-ups.

OPTION 2 (Recommended): Select Pop-up Blocker Settings.

Under Address of Website to allow type: www.clicktate.com and then press ADD.



Press the close button.

Using Clicktate with Pop-Ups and Tabbed Browsing

With Clicktate, users have the option of formatting how the patient console window appears. The browser can be set to allow the console to open in a new tab (window) OR as a pop-up.

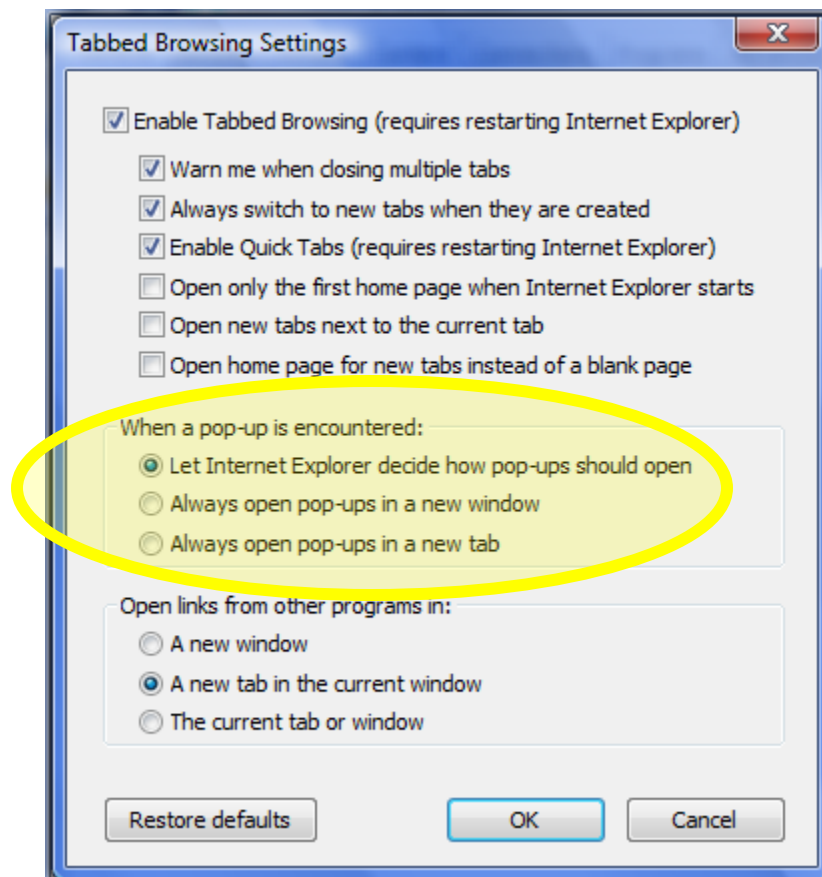
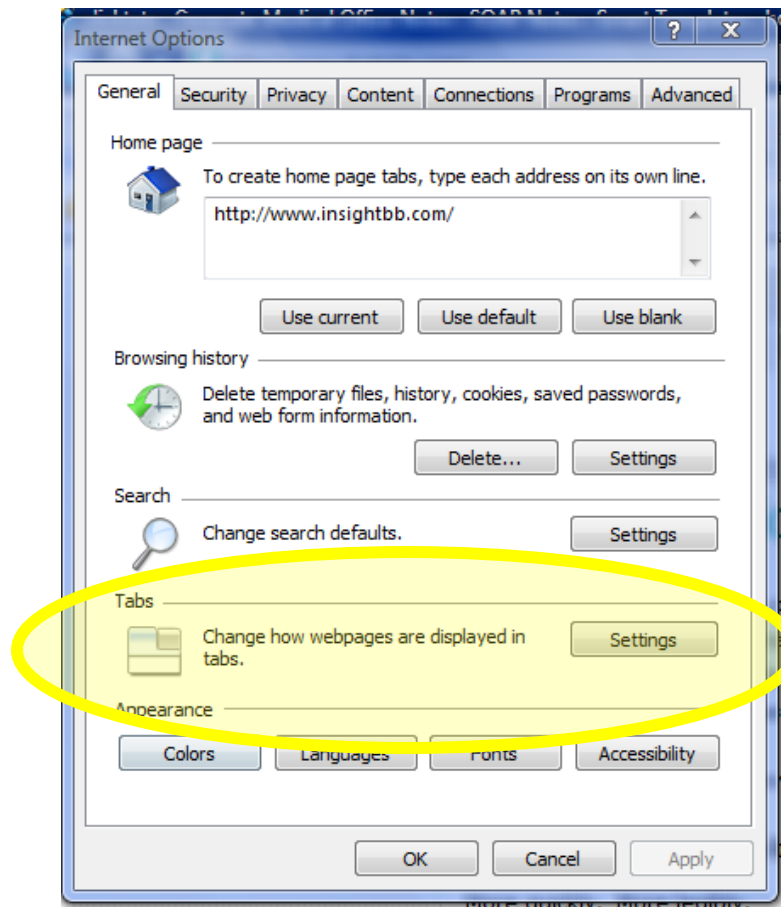
To change this setting, go to the tools menu at the top of the internet browser.



Select Internet Options from the Drop-down menu and Select Settings under the Tab Menu.

Tools>>Internet Options>>Settings (Tabs Menu)

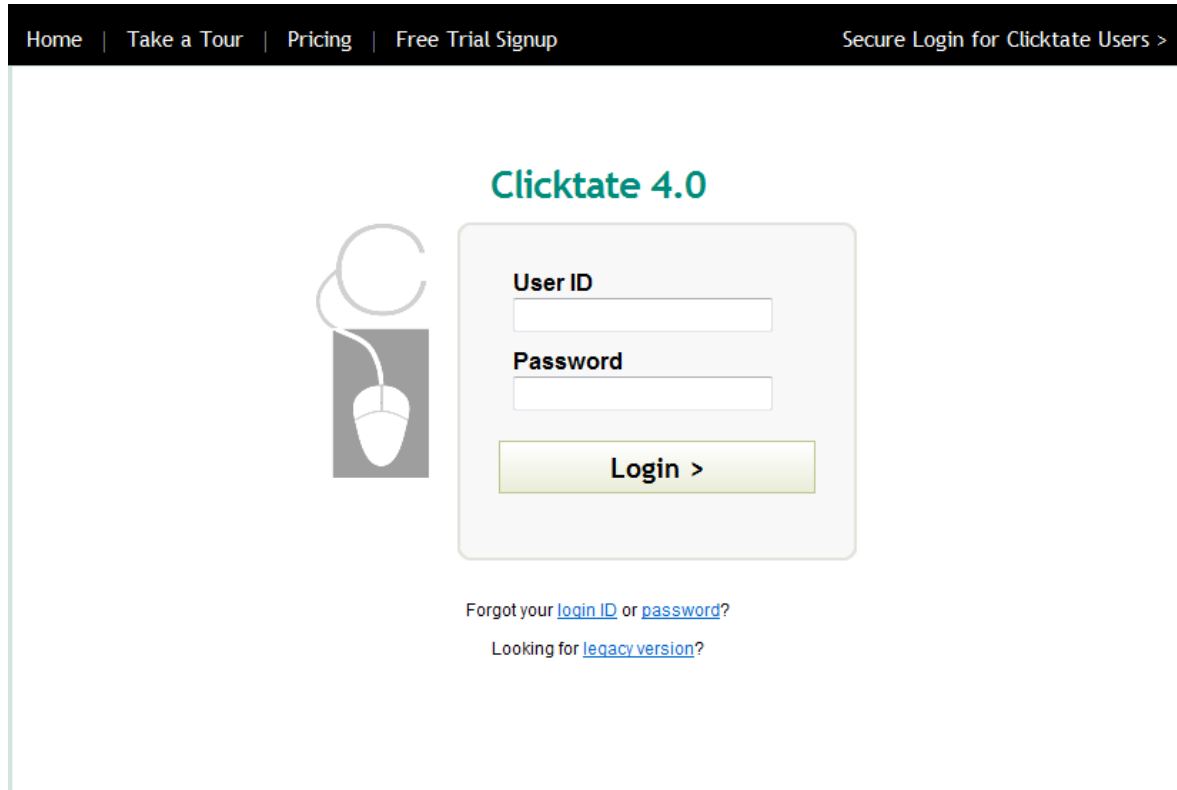
Then choose how pop-ups should be handled based on your personal preference.



Section III: Getting Started

Logging On

To log on to clicktate.com, go to the home page: www.clicktate.com. You will see a link that will direct you to the secure log-in page. There you will find the log-in box.

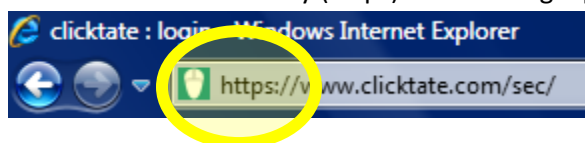


Type in your User ID and your Password. If you forget your user ID or Password, select the link at the bottom of the sign-in box. **Both the User ID and Password are CASE Sensitive.** For instance, the Password “SamPle3” is NOT the same as “sample3”. Each Password must contain at least 6 characters, at least one of which must be numeric.

After you input your User ID and Password, press the [Login >](#) button.

You will be directed to the Home Page.

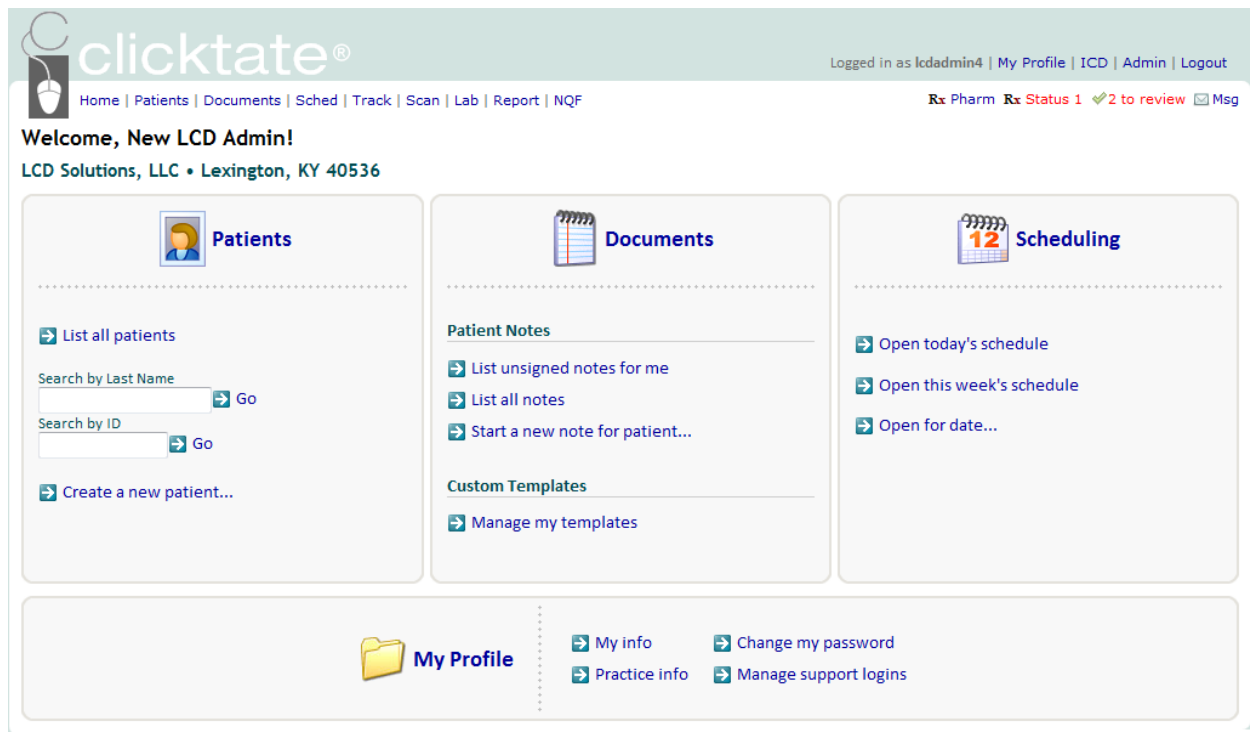
Clicktate uses SSL security (https) from the login page forward.



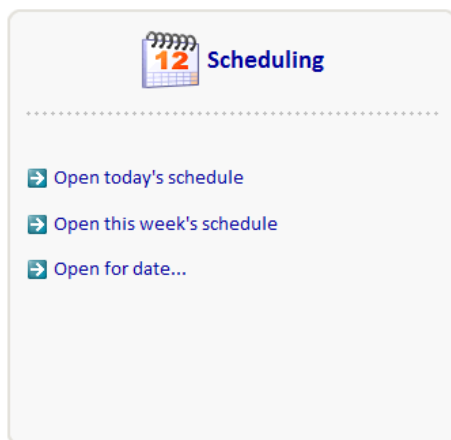
Section IV: Navigation through the System and Scheduling

The Home Page

The Home Page is the initial page when you access Clicktate. From the home page, you can navigate to any other section of Clicktate. You can navigate by schedule, by individual patient, or you can create a new patient. You can also change your personal profile or create or modify custom designed templates from this page.



Patient Data Entry: Entering New Patients into Clicktate™



There are multiple methods to enter new patients into Clicktate. Patients may be entered from the scheduling module at the time of appointment scheduling.

To enter patients from the scheduling module, first select one of the options from the scheduling menu on the home page.

Any of the options may be selected including “Scheduling”, “Open today’s schedule”, “Open this week’s schedule”, or “Open for date...”

Selecting any of these options will open a calendar box and, from any date, a patient may be entered into the system.

The screenshot shows the Clicktate Scheduling interface. At the top, the Clicktate logo is on the left, and user information (Logged in as lcdadmin4) and navigation links (My Profile, ICD, Admin, Logout) are on the right. Below the header, there's a navigation bar with links: Home, Patients, Documents, Sched, Track, Scan, Lab, Report, NQF. On the right of this bar are links for Rx Pharm, Rx Status 1, 2 to review, and a Msg icon. The main section is titled "Scheduling:" with a dropdown menu set to "New LCD Admin". To the right are "Customize" and "Print" links. The calendar view is for "Friday, April 27, 2012", with "Thursday, April 26" and "Saturday, April 28" visible on the sides. The calendar grid shows time slots from 00 to 45 minutes past the hour for hours 9, 10, 11, and 12. A "View entire week" link is centered above the grid.

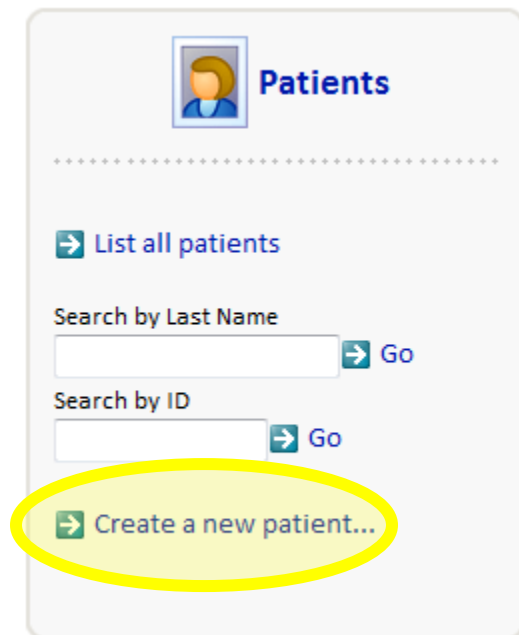
Selecting any time slot will allow a new patient to be entered into the system or you may search the Clicktate™ database for an existing patient.

The screenshot shows the "Patient Selector" dialog box. It has a title bar with a close button. Inside, there's a "Search for a patient" section with a "Customize" link. Below this are input fields for "Last Name", "First", and "Patient ID". There are three buttons: "Search" (with a magnifying glass icon), "Create New Patient..." (with a plus icon), and "Cancel". Below the input fields is a list of patient records, each with a Patient ID, a name, and a date of birth. A blue arrow points from the "Search" button to the list. At the bottom, there's a section titled "Or, mark time as unavailable" with an "Unavailable..." button and a "Cancel" button.

Patient ID	Name	Date of Birth
092384	Rogers, Tim	15-Jun-1937
345634	Logan, Arnold	05-Jan-1946
987543	Fila, Chick	09-Mar-1995
2304892	Walker, Randy	02-Jan-1991
98734598	Cuppy, Ronald	20-Aug-1963
2343254	Thumb, Tom	08-Sep-1981
345345	Melendez, Michele	13-Jan-1982
039458	Bower, Mandy	08-Nov-1979
90234020	Green, Cowan	13-Jul-1949
56876534	Lawrence, Thelma	17-Jan-1990

In addition, **new patients may also be entered from the Patients menu.**

By selecting the “Create New Patient...” tab, a new patient may be entered into the system.



After selecting the “Create a new patient...” link, the Initial Patient Editor window will appear. In this window, the initial patient data such as ID, Name, Gender and Date of Birth will be entered.

A screenshot of a 'Create a Patient' window. The window has a title bar with the text 'Create a Patient' and a close button. The main area contains several input fields: 'Patient ID' (a single text box), 'Last Name' (a text box), 'First' (a text box), 'Middle' (a text box), 'Gender' (a dropdown menu with 'Female' selected), and 'Birth' (a text box with a calendar icon to its right). At the bottom of the window are two buttons: 'Create and Continue >' and 'Cancel'.

Since Clicktate utilizes a specified date of birth format, it is best to use the calendar icon to enter the birthdate.

Create a Patient

Patient ID: 8203490

Last Name: Winter First: Snowy Middle: R

Gender: Female Birth: 16-Apr-1958

Create and Continue > **Cancel**

After entering the initial patient data, select “Create and Continue>”

After creating the patient, the patient Facesheet will automatically open.

clicktate®

Logged in as lcdadmin4 | My Profile | ICD | Admin | Logout

Home | Patients | Documents | Sched | Track | Scan | Lab | Report | NQF

Rx Pharm Rx Status 1 ✓ 1 to review Msg

Winter, Snowy R

ID: 8203490 DOB: 16-Apr-1958 Age/Sex: 54 female

Address: Phone(s):

Open Download/Print Search for patient

Upload Add Notes

Quick Links

- New Appointment...
- Record Today's Vitals...
- Create New Document...
- New Message...

Active Allergies

(None Known)

Selecting the “Open” icon in the Patient Data pane will open the option box for entering detailed patient data. This includes emergency contact information, family information, insurance and legal information and several custom fields.

Patient Information

Winter, Snowy R Edit

Patient ID: 8203490 Gender: Female Birth: 16-Apr-1958 Age: 54

Race/Ethnicity: Language: Primary Phys:

Contact • Insurance • Legal • Family • Custom

Contact

Home: Edit

Emergency: Edit

Pharmacy: Edit

Insurance

Plan Group/Policy # Effective: Edit

Plan Group/Policy # Effective: Edit

Legal

Family Release Preference: Edit

Exit

In the New Patient Entry window, required fields include the Patient ID, Last Name, First Name, Gender, and Birthdate.

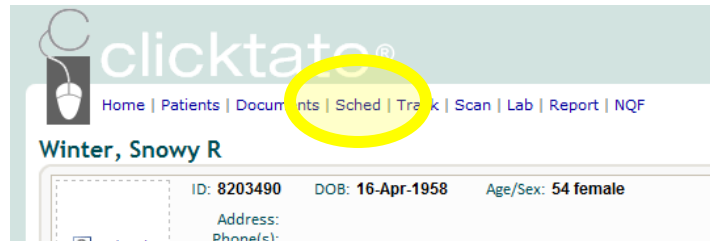
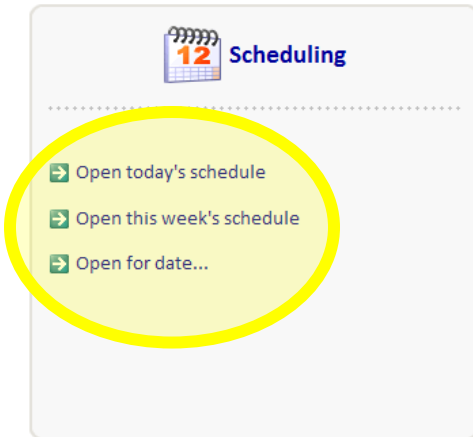
The birthdate and gender are important, as Clicktate will assign certain questions only in age and gender appropriate situations. In addition, the notes generated from Clicktate templates will automatically assign the correct gender identifiers. For instance, questions regarding sexual activity and smoking will be deleted for children.

Address, City, State, Zip code, Phone Numbers and Email addresses are NOT optional as other features in Clicktate such as electronic prescribing and the patient portal utilize this information.

New patients may be entered from the home page, from the patient page or from the calendar module.

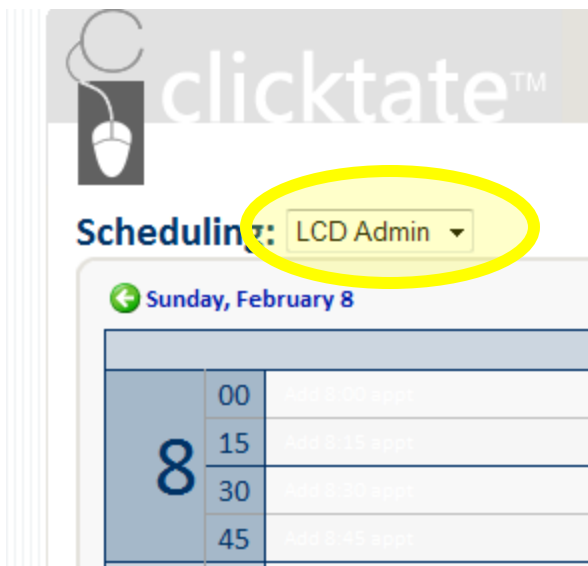
Entering an Appointment

To enter an appointment, first select one of the scheduling options from the Clicktate™ home page or select “Sched” from the navigation bar which is found at the top of all pages in Clicktate™. You will then be directed to the physician schedule. The schedule will default to the current date.



Select the date and time to begin the appointment entry process.

Select the correct provider from your group.



Patient Selector [X]

Search for a patient [Customize](#)

Last Name First
 Patient ID

Search Create New Patient... Cancel

8203490	Winter, Snowy R	16-Apr-1958
092384	Rogers, Tim	15-Jun-1937
345634	Logan, Arnold	05-Jan-1946
987543	Fila, Chick	09-Mar-1995
2304892	Walker, Randy	02-Jan-1991
98734598	Cuppy, Ronald	20-Aug-1963
2343254	Thumb, Tom	08-Sep-1981
345345	Melendez, Michele	13-Jan-1982
039458	Bower, Mandy	08-Nov-1979
90234020	Green, Cowan	13-Jul-1949

Or, mark time as unavailable

Unavailable... Cancel

From this window, a new patient may be created, or you may search for an established patient by entering a Patient ID, Partial Patient ID, Name, or Partial Name. Selecting the “Cancel” button will return you to the scheduling page.

Patient Selector [X]

Search for a patient [Customize](#)

Last Name First
 Patient ID

Search Create New Patient... Cancel

09238	Test, Darla	09-Mar-2009
123456	Test, Paula	31-Dec-1969
09238023	Test, Troy	02-Jun-1959
84593	Tester, Tony	01-Jan-2010

Or, mark time as unavailable

Unavailable... Cancel

Here, a search for a patient with the last name “test” has returned four patients. By selecting one of these patients, an appointment for that patient may be added to the schedule.

New Appointment > Test, Darla

Patient

Test, Darla [Edit](#)

ID: **09238** DOB: **09-Mar-2009**

Address:

Phone:

[Go to patient's facesheet](#) [Choose another...](#)

Appointment

Date: **2012-04-27** Time: **10:00 AM**

Type: **(No Type)** [Customize](#)

Duration: **0 hours** and **0 minutes**

Status: **(No Status)** [Customize](#)

Comments:

[Save and Continue >](#) [Cancel](#)

Now, entering an appointment is easily accomplished by selecting the appointment type and duration.

The appointment status may be changed to arrived, late, DNKA, rescheduled, or other options as needed. There is also a field for comments if additional notes need to be included.

The “Cancel” button is to *cancel the entering of an appointment*, not the actual appointment.

To cancel an *already scheduled appointment*, use the Status Dropdown menu.

Appointment type and status are user customizable fields, and may be changed according to individual practice needs.

New Appointment > Test, Darla

Patient

Test, Darla

ID: 09238 DOB: 09-Mar-2009

Address:

Phone:

Edit

Go to patient's facesheet

Choose another...

Appointment

Date: 2012-04-27

Time: 10:00 AM

Type: Acute

Customize

Duration: 0 hours and 20 minutes

Status: (No Status)

Customize

Comments: Blood pressure check. Needs urinalysis prior to appointment.

Save and Continue >

Cancel

Here, an appointment for the selected patient is designated as a 20 minute Acute visit. The patient needs a urinalysis before the appointment. Select the “Save and Continue>” link to schedule the appointment.

The appointment will appear on the schedule and a menu box will open to allow the immediate generation of a note if desired.

clicktate

Home | Patients | Documents | Scheduling

Scheduling: New LCD Admin

Thursday, April 26

9	00	
	15	
	30	
	45	
10	00	Test, D
	15	
	30	
	45	
11	00	
	15	
	30	
	45	
12	00	
	15	
	30	
	45	

Appointment > Test, Darla

Patient

Test, Darla

ID: 09238 DOB: 09-Mar-2009

Address:

Phone:

Edit

Go to patient's facesheet

Appointment

April 27 @ 10:00 AM (20 minutes)

Type: Acute

Status: (No Status)

Comments: Blood Pressure check. Needs urinalysis prior to appointment.

Created: Today, 12:55PM by New LCD Admin

Edit

History

Today, 10:00AM

Appt: Acute

[No status selected]


Show notes

New Note...

Exit

Appointment > Test, Darla


Patient

Test, Darla  Edit


ID: 09238 DOB: 09-Mar-2009

Address:

Phone:

 Go to patient's facesheet

Appointment

April 27 @ 10:00 AM (20 minutes)  Edit


Type: **Acute**

Status: **(No Status)**



Comments: **Blood Pressure check. Needs urinalysis prior to appointment.**

Created: Today, 12:55PM by New LCD Admin

History ☐ Show notes

Today, 10:00AM  Appt: **Acute**

[No status selected]

 New Note...  Exit

A **new note** may be started by selecting “New Note...” or selecting “Exit” will close this menu.

A link also appears at the top of the box which will navigate directly to the patient’s Facesheet.

Appointments may be double booked (or more) by selecting the same time and again adding another patient.

Thursday, April 26

9	00	
	15	
	30	
	45	
10	00	Test, D
	15	
	30	
	45	
11	00	
	15	

By selecting the patient name from the appointment calendar, the appointment window will open.

To cancel or indicate that a patient has arrived, select either the Edit link or the Status link.

Appointment > Test, Darla [X]

Patient

Test, Darla [Edit]

ID: 09238 DOB: 09-Mar-2009
Address:
Phone:

[Go to patient's facesheet]

Appointment

April 27 @ 10:00 AM (20 minutes) [Edit]

Type: Acute
status: (No Status)
Comments: Blood Pressure check. Needs urinalysis prior to appointment.
Created: Today, 12:55PM by New LCD Admin

History [Show notes]

Today, 10:00AM [Appt: Acute]
[No status selected]

[New Note...] [Exit]

From within the “Edit” link, the appointment Status may be changed, or the appointment may be deleted.

Appointment > Test, Darla

Patient

Test, Darla [Edit](#)

ID: 09238 DOB: 09-Mar-2009

Address:

Phone:

[Go to patient's facesheet](#)

Appointment

Date: 27-Apr-2012 Time: 10:00 AM

Type: Acute [Customize](#)

Duration: 8 hours and 20 minutes

Status: (No Status) [Customize](#)

Comments: Blood Pressure check. Needs urinalysis prior to appointment.

[Save and Exit](#) [Delete](#) [Cancel](#)

Scheduling for Multiple Providers within the Same Practice

Schedules may be created and maintained for multiple providers within the same practice.

The scheduling module can even be used to create nurse schedules, providing the nurse has a user ID. To specify with whom a patient is to be scheduled use the Scheduling dropdown menu.

To Link providers within the practice, please contact Clicktate.

clicktate™

[Home](#) | [Patients](#)

Scheduling: Dr. LCD

User Customization Options within Scheduling and Patient Management

Multiple options may be customized to user or practice preferences within Clicktate.

To customize the calendar module, select the “Customize” button in the upper right corner above the calendar.

A screenshot of the 'Customize Schedule' dialog box. The dialog has a title bar with a close button. It contains two main sections: 'Calendar Display' and 'Other'. The 'Calendar Display' section includes fields for 'Work Week' (Start: Monday, Length: 5 days), 'Time Slots' (From: 09:00 AM, To: 05:00 PM, Size: 15 minute), and 'Appt Label' (Last, F. (Phone)). There are three buttons at the bottom: 'Save Changes', 'Reset to Default', and 'Cancel'. The 'Other' section contains two links: 'Customize Appointment Types' and 'Customize Arrival Status', each preceded by a wrench icon.

Here, the work week may be specified and time slot intervals may be entered according to provider preference.

By selecting “Customize Appointment Types” or “Customize Arrival Status” these may be set to user preference as well. To customize appointment types, enter the types of appointments to be scheduled for the selected provider.

Customize Appointment Types

☒ Active?
 Acute

0

hours

20

minutes

☒ Active?
 Follow-up

0

hours

15

minutes

☒ Active?
 New patient

1

hours

0

minutes

☒ Active?
 Exam

0

hours

30

minutes

☒ Active?
 Physical

1

hours

0

minutes

☒ Active?
 Family Consultation

0

hours

30

minutes

☒ Active?
 Medicine Check

0

hours

15

minutes

☒ Active?
 Well Child

0

hours

30

minutes

☒ Active?
 Procedure- Simple

0

hours

30

minutes

☒ Active?
 Procedure- Complex

1

hours

0

minutes

☒ Active?
 Pre-operative Consultation

0

hours

45

minutes

☒ Active?
 Suture Removal

0

hours

10

minutes

☒ Active?
 Prenatal Consultation

0

hours

20

minutes

☒ Active?
 Gynecologic Examination

0

hours

20

minutes

Save Changes

Reset to Default

Cancel

Customize Schedule Status

☒ Active?
 Arrived

Set Color

☒ Active?
 test

Set Color

☒ Active?
 Late arrival (minor): seen

Set Color

☒ Active?
 Late arrival (severe): seen

Set Color

☒ Active?
 Late arrival (severe): rescheduled

Set Color

☒ Active?
 Late arrival (severe): cancelled

Set Color

☐ Active?

Set Color

☒ Active?
 DNKA

Set Color

☐ Active?

Set Color

☒ Active?
 Patient cancelled (before cutoff)

Set Color

☒ Active?
 Patient cancelled (after cutoff)

Set Color

☒ Active?
 Patient rescheduled (before cutoff)

Set Color

☒ Active?
 Patient rescheduled (after cutoff)

Set Color

☐ Active?

Set Color

☒ Active?
 Office rescheduled

Set Color

☒ Active?
 Office cancelled

Set Color

☐ Active?

Set Color

Save Changes

Reset to Default

Cancel

In the “Customize Arrival Status”, the patient status may be set as well as the color of which each status will appear on the schedule.

Blocking Time Periods

To block time periods when a provider is not available, choose a start time on the schedule and select it **as if you are scheduling an appointment**.

For instance, to block the time period from Noon- 1 PM for lunch each day, first choose the start time of the appropriate time period.

The screenshot shows the Clicktate scheduling interface. The header includes the Clicktate logo, user login information (Logged in as lcdadmin4), and navigation links (Home, Patients, Documents, Sched, Track, Scan, Lab, Report, NQF). The main area displays a weekly schedule for Friday, April 27, 2012. The interface includes a 'Scheduling:' dropdown menu set to 'New LCD Admin'. The schedule grid shows time slots for the week. A yellow oval highlights the 11:45 slot on Friday, which is currently empty, indicating the start time for blocking a time period.

The Create Appointment menu will appear.

The screenshot shows the Patient Selector dialog box. The dialog box has a title bar 'Patient Selector' and a search section with fields for Last Name, First, and Patient ID. Below the search fields are buttons for Search, Create New Patient..., and Cancel. A list of patients is displayed below the search section. At the bottom, there is a section 'Or, mark time as unavailable' with a yellow oval highlighting the 'Unavailable...' button.

Patient ID	Patient Name	Date of Birth
09238	Test, Darla	09-Mar-2009
84593	Tester, Tony	01-Jan-2010
09238023	Test, Troy	02-Jun-1959
123456	Test, Paula	31-Dec-1969
8203490	Winter, Snowy R	16-Apr-1958
092384	Rogers, Tim	15-Jun-1937
345634	Logan, Arnold	05-Jan-1946
987543	Fila, Chick	09-Mar-1995
2304892	Walker, Randy	02-Jan-1991
98734598	Cuney, Ronald	20-Aug-1963

Choose “Unavailable...” and the Edit Unavailability menu will appear where the title, time and repeat status may be added.

Edit Unavailability

Unavailability Event

Title:

Date: Time:

Duration: and

Repeats:

Comments:

To block one-hour for lunch, change the menu settings as shown and set a daily repeat.

Edit Unavailability

Unavailability Event

Title:

Date: Time:

Duration: and

Repeats:

Every: day

Until:

Comments:

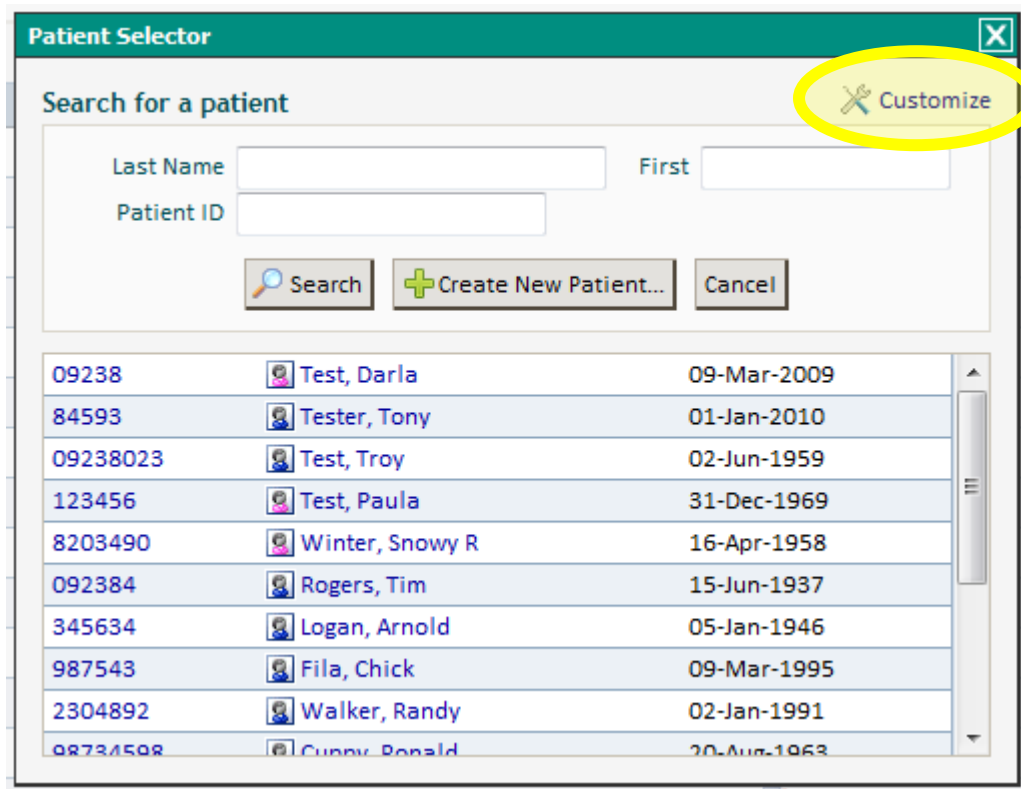
The calendar will reflect the change for the current and each additional date.

The screenshot displays the Clicktate scheduling interface. At the top, the Clicktate logo is on the left, and user information 'Logged in as lcdadmin4 | My Profile | ICD | Admin | Logout' is on the right. Below the logo is a navigation bar with links: Home, Patients, Documents, Sched, Track, Scan, Lab, Report, NQF. On the right of the navigation bar are links for 'Rx Pharm', 'Rx Status 1', '1 to review', and 'Msg'. The 'Scheduling' section shows a dropdown menu with 'New LCD Admin' selected. To the right of the dropdown are links for 'Customize' and 'Print'. The main calendar view is for 'Friday, April 27, 2012', with navigation for 'Thursday, April 26' and 'Saturday, April 28'. The calendar grid shows time slots from 9:00 to 4:45. A 'Test, D' appointment is booked from 9:00 to 9:45, and a 'Lunch' block is shown from 12:00 to 12:45. The interface also includes a 'View entire week' link.

It will still be possible to “overbook” even blocked time periods such as lunch by selecting the area on the calendar in the desired time period beside the blocked time.

Customization of the Patient Search Option

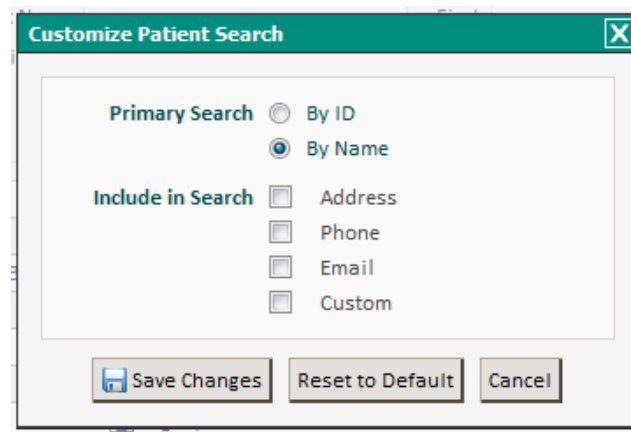
Depending on personal preference, the patient search option may be customized to reflect whether the user desires to search by name or by medical record number. From the Patient Selection menu, select the “Customize” link.



The **Patient Selector** dialog box features a title bar with a close button. Below the title bar is a section titled "Search for a patient". This section contains three input fields: "Last Name", "First", and "Patient ID". Below these fields are three buttons: "Search" (with a magnifying glass icon), "Create New Patient..." (with a plus icon), and "Cancel". In the top right corner of the dialog, there is a "Customize" button with a wrench icon, which is highlighted by a yellow circle. Below the search section is a table listing patient records.

09238	Test, Darla	09-Mar-2009
84593	Tester, Tony	01-Jan-2010
09238023	Test, Troy	02-Jun-1959
123456	Test, Paula	31-Dec-1969
8203490	Winter, Snowy R	16-Apr-1958
092384	Rogers, Tim	15-Jun-1937
345634	Logan, Arnold	05-Jan-1946
987543	Fila, Chick	09-Mar-1995
2304892	Walker, Randy	02-Jan-1991
98734598	Curry, Ronald	20-Aug-1963

The user will have the option of searching by either name or medical record number, and the search box will default to place the cursor in the appropriate text field upon opening the customization tool. Users may also specify other parameters to include in the search. This includes address, phone number, e-mail and items located in the custom fields.



The **Customize Patient Search** dialog box has a title bar with a close button. The main area contains two sections. The "Primary Search" section has two radio buttons: "By ID" and "By Name", with "By Name" selected. The "Include in Search" section has four checkboxes: "Address", "Phone", "Email", and "Custom", all of which are currently unchecked. At the bottom of the dialog are three buttons: "Save Changes" (with a floppy disk icon), "Reset to Default", and "Cancel".

Section V: Working with Patient Documents and Notes

Working with Patient Documents

Patient documentation may be started at multiple entry points throughout the system:

- From the Scheduling Page
- From the Documents Section of the home page
- From a Patient Facesheet

Starting Notes from the Scheduling Module


To begin a patient note from the scheduling module, start by selecting a patient from the schedule or placing a new patient on the schedule as previously shown. Select the patient for whom a note is to be created.

View entire week					
9	00	Add 9:00 appt	1	00	Add 1:00 appt
	15	Add 9:15 appt		15	Add 1:15 appt
	30	Add 9:30 appt		30	Add 1:30 appt
	45	Add 9:45 appt		45	Add 1:45 appt
10	00	Test, Darla	2	00	Add 2:00 appt
	15	Add 10:15 appt		15	Add 2:15 appt
	30	Add 10:30 appt		30	Add 2:30 appt
	45	Add 10:45 appt		45	Add 2:45 appt
11	00	Add 11:00 appt	3	00	Add 3:00 appt
	15	Add 11:15 appt		15	Add 3:15 appt
	30	Add 11:30 appt		30	Add 3:30 appt
	45	Add 11:45 appt		45	Add 3:45 appt
12	00	Lunch	4	00	Add 4:00 appt
	15			15	Add 4:15 appt
	30			30	Add 4:30 appt
	45			45	Add 4:45 appt

Clicking on Darla Test will produce the appointment status pop-up. Selecting the “New Note...” button will begin a new note on the patient console.

Appointment > Test, Darla


Patient

Test, Darla  **Edit**


ID: 09238 DOB: 09-Mar-2009

Address:

Phone:

 **Go to patient's facesheet**

Appointment


April 27 @ 10:00 AM (20 minutes)  **Edit**


Type: Acute

Status: (No Status)

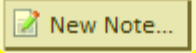

Comments: Blood Pressure check. Needs urinalysis prior to appointment.

Created: Today, 12:55PM by New LCD Admin

History  **Show notes**

Today, 10:00AM  **Appt: Acute**

[No status selected]

 **New Note...**  **Exit**

The patient appointment status can also be changed from this page to Arrived, Cancelled, etc. by clicking the Edit button OR by selecting the “(No Status)” field in the above example. This feature is useful if the front office or nursing staff want to track a patient’s progress through the appointment or to let the physician easily track the patient’s appointment status. In the example below, the appointment status has been changed to “Arrived”.

After changing the Appointment Status, select “Save and Exit”.

Appointment > Test, Darla

Patient

Test, Darla [Edit](#)

ID: 09238 DOB: 09-Mar-2009

Address:

Phone:

[Go to patient's facesheet](#)

Appointment

Date: 27-Apr-2012 Time: 10:00 AM

Type: Acute [Customize](#)

Duration: 0 hours and 20 minutes

Status: Arrived [Customize](#)

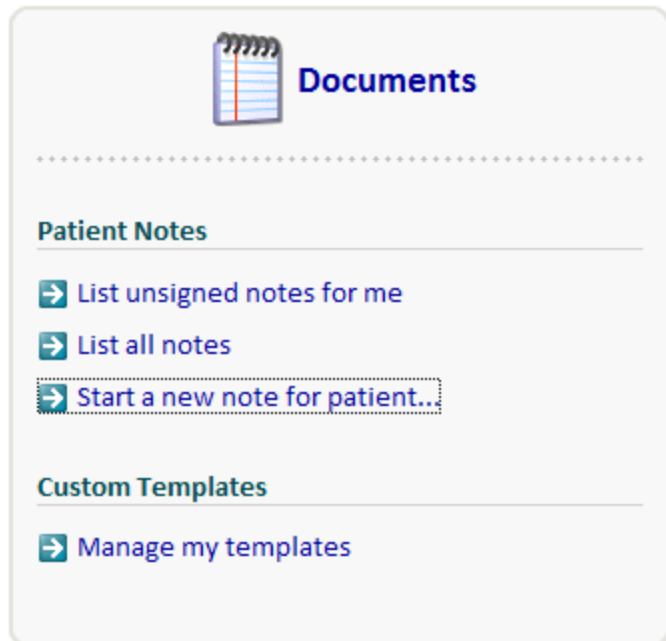
Comments: Blood Pressure check. Needs urinalysis prior to appointment.

[Save and Exit](#) [Delete](#) [Cancel](#)

The appointment status change will be reflect by a color change on the schedule.

9	00	Add 9:00 appt
	15	Add 9:15 appt
	30	Add 9:30 appt
	45	Add 9:45 appt
10	00	Test, Darla
	15	Add 10:15 appt
	30	Add 10:30 appt
	45	Add 10:45 appt

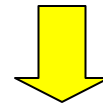
Starting Notes from and Navigation from the Documents Module




Notes may also be created from the Documents section of the Home page.

















To start a note from this section, select “Start a new note for patient...”. This will open the Document Manager page with the Patient Selector pop-up to allow the selection of a patient.

From the Patient Selector, choose the patient for whom you wish to create a note.




Document Manager

Showing: **All notes for** [Everyone]  [Show unsigned notes only](#)

Document	DOS
 Medical Note	Today
 Medical Note	04/26
 Psychiatric Note	04/26
 Psychiatric Note (Signed)	04/24
 Medical Note	04/24
 Medical Note	04/24
 Psychiatric Note	04/24
 Psychiatric Note (Signed)	04/24
 Psychiatric Note (Signed)	04/24
 Psychiatric Note	04/23
 Psychiatric Note	04/23
 Psychiatric Note	04/23
 Psychiatric Note	04/23
 Psychiatric Note	04/23
 Psychiatric Note	04/23
 Psychiatric Note	04/23



Patient Selector











Search for a patient  [Customize](#)

Last Name

First

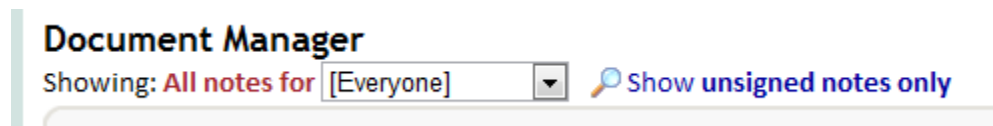
Patient ID

 Search
  Create New Patient...

09238	 Test, Darla	09-Mar-2009
84593	 Tester, Tony	01-Jan-2010
09238023	 Test, Troy	02-Jun-1959
123456	 Test, Paula	31-Dec-1969
8203490	 Winter, Snowy R	16-Apr-1958
092384	 Rogers, Tim	15-Jun-1937
345634	 Logan, Arnold	05-Jan-1946
987543	 Fila, Chick	09-Mar-1995
2304892	 Walker, Randy	02-Jan-1991
08734508	 Curry, Ronald	20-Aug-1963

From this pop-up either select a patient name from the list of recent patients or input a patient name, partial name, or close the Patient Selector Box to select a note from the Notes List.

From the notes list, you may select from all notes, all unsigned noted, or notes for a specific provider from within a practice group.



Patient Lists in Clicktate are defaulted to show the patients that have been reviewed recently. This list appears with the most recently viewed patient chart listed first.

Choosing a Note Type, Date of Service and Note Recipient

When you start a patient note, you will need to specify a note type. For most providers, the note type will default to Medical Note, which is the standard medical note found in Clicktate. In addition, from this page, notes may be sent to another provider or support person (nurse, lab technician, front office staff) from within the same office. Notes may also be started from a user defined custom template that has been saved by the specific user. To change the default value for the “Send To” or “Template” field, choose the “Set as default” link beside the appropriate field.

The screenshot shows a 'Create New Document' dialog box for a patient named 'Test, Darla'. The 'Date of Service' is set to '27-Apr-2012'. The 'Send To' field is empty with a dropdown arrow and a 'Set as default' link. The 'Document Type' is set to 'Medical Note' with a dropdown arrow and a 'Set as default' link. Below these fields are three options for creating a new note:

- Blank Medical Note**: Indicated by a yellow arrow labeled 'Start Blank/New Note'.
- Replicate from Patient History**: Subtext 'Medical Note DOS: 07-Jul-2009'. Indicated by a yellow arrow labeled 'Replicate a Prior Note'.
- Apply Custom Template:**: A dropdown menu showing 'cad patient (Medical Note)'. Indicated by a yellow arrow labeled 'Start User Template Note'.

A 'Cancel' button is located at the bottom of the dialog box.

To start a note using one of the standard Clicktate templates, first specify a note type from the “Template” menu and then choose “Blank Medical Note”.

To replicate (or reuse) a prior note, select the middle box, “Replicate from Patient History”. This function is not available for notes created prior to June 2009.

To start a note using a user defined custom template, from the bottom note creation box, first select the name of the custom template from the drop down list. Here a template that the user has specified as dm-htn has been chosen. Then select “Apply Custom Template:”

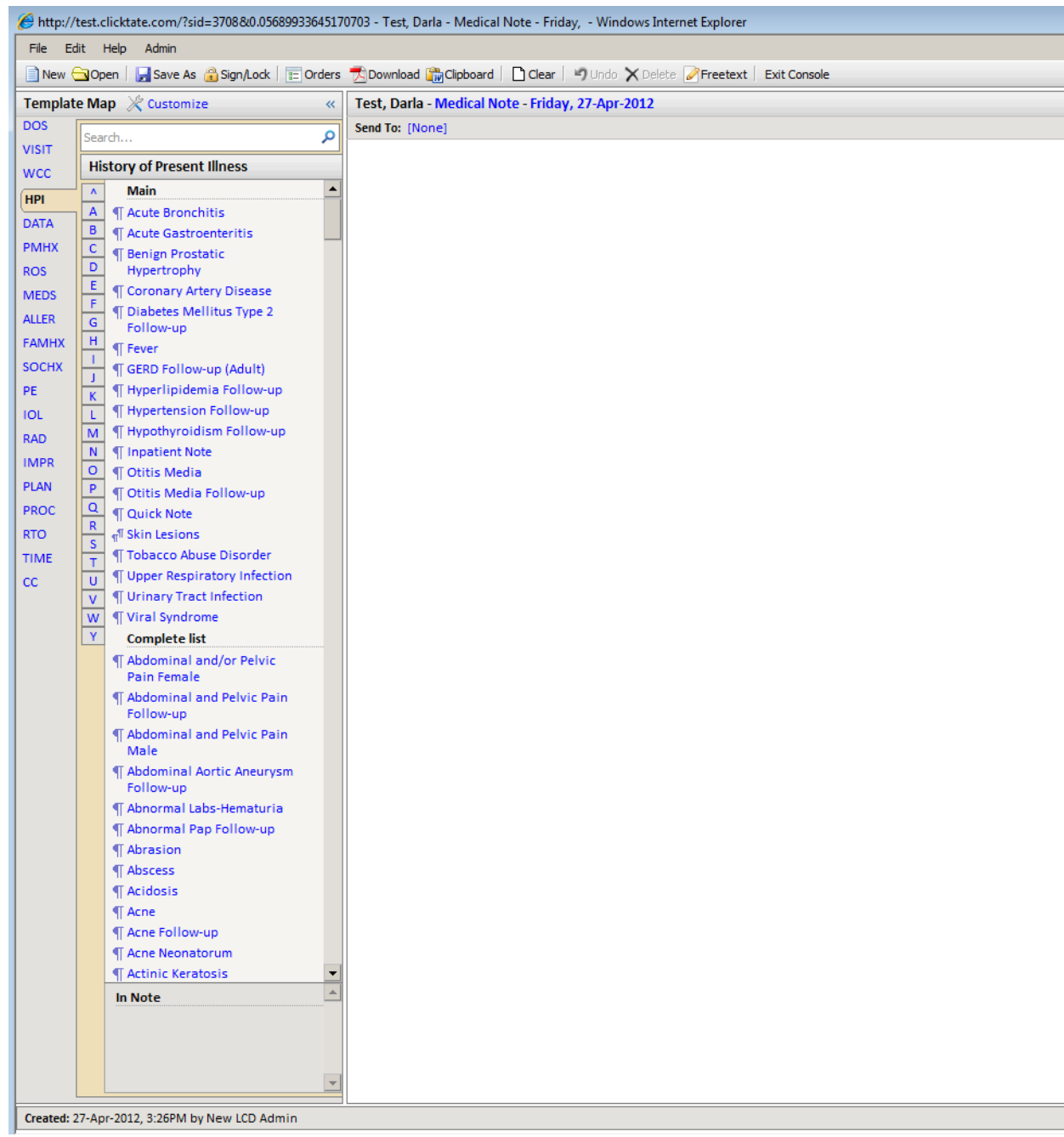
To specify a user from within the practice group who will receive the note for review, select the desired user from the “Send To” menu.

The Date of Service can be changed by selecting the appropriate date from the “Date of Service” menu.

Section VI: The Patient Console: Generating Notes and Letters

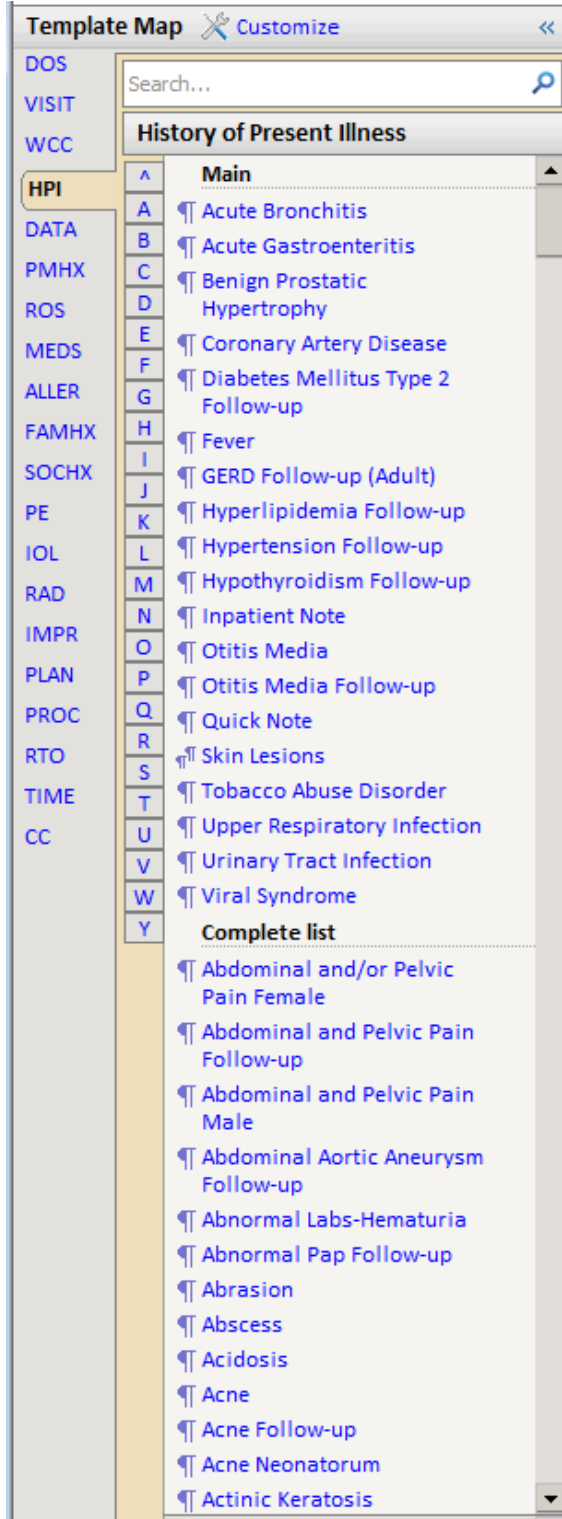
The Patient Console

The patient console is the Documentation component of Clicktate™. From the console, notes of various types may be generated and custom templates may be designed.



The Template Map

The Template Map is the section of the console where various notes and templates may be selected for insertion into the note being created.



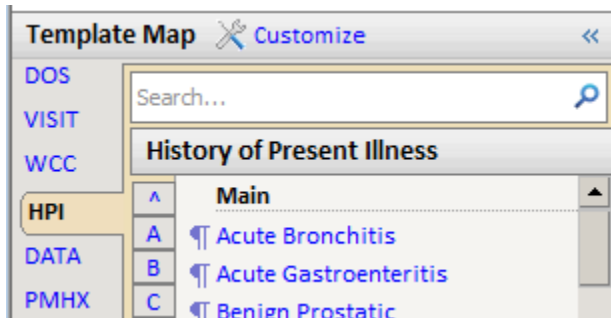
This is the template map for the med note. The med note is divided into sections including:

- DOS- the Date of Service
- VISIT- Visit Data
- WCC- Well Child Checks
- HPI- History of Present Illness
- DATA- Data Elements
- PMHX- Past Medical History
- ROS- Review of Systems
- MEDS- Medications
- ALLER- Allergies
- FAMHX- Family History
- SOCHX- Social History
- PE- Physical Examination
- IOL- In Office Labs
- RAD- Radiology
- IMPR- Impression
- PLAN
- PROC- Procedures
- RTO- Return to Office
- TIME- Documentation of Time
- CC- Carbon Copy
-

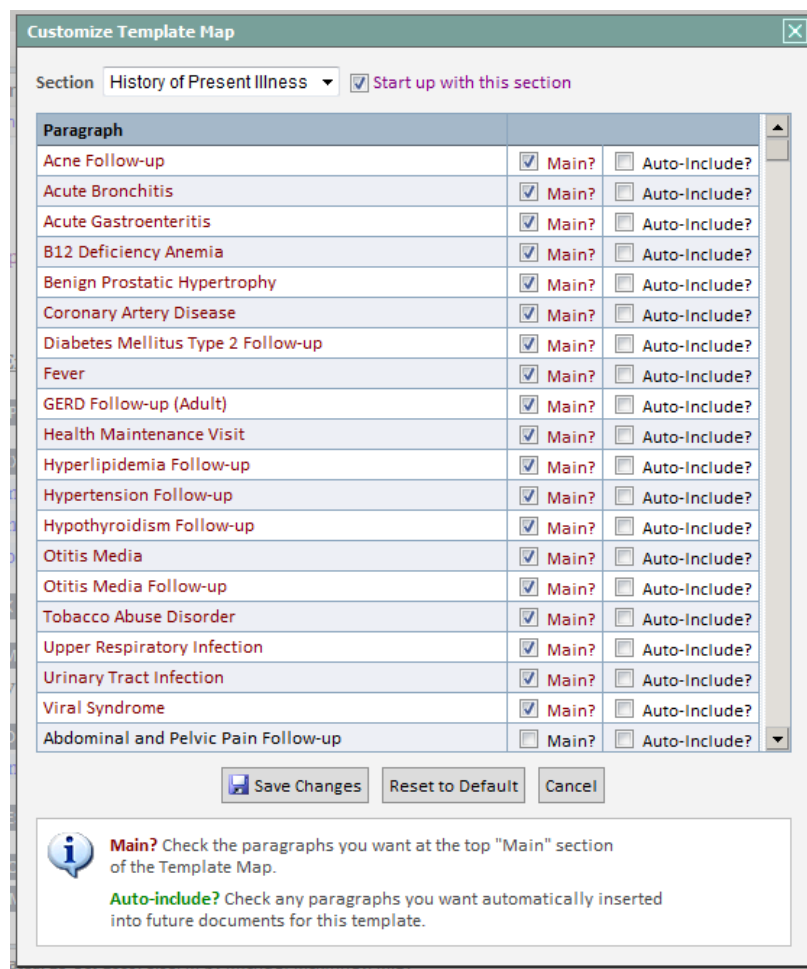
In this example, HPI is selected, and various HPI elements are visible in the scrollable list, starting with the MAIN (commonly selected items) section and then an alphabetical list of all HPI templates available.

Customizing the Template Map

The template map may be customized to reflect those items that a provider encounters more frequently. To customize the template map, select “Customize” which is found in the title bar of the template map.

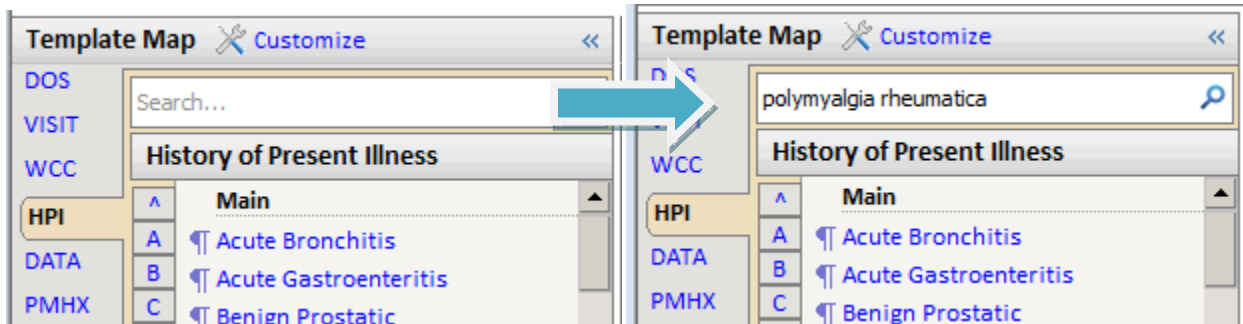


By utilizing the “Customize” function, users may select those items which should appear in the Main section of the template map and unselect those that should not. The section which appears when the console appears may also be preset. Another feature is the ability to auto-include a section in each note. This will automatically insert any “Auto-include” paragraph into each note created.

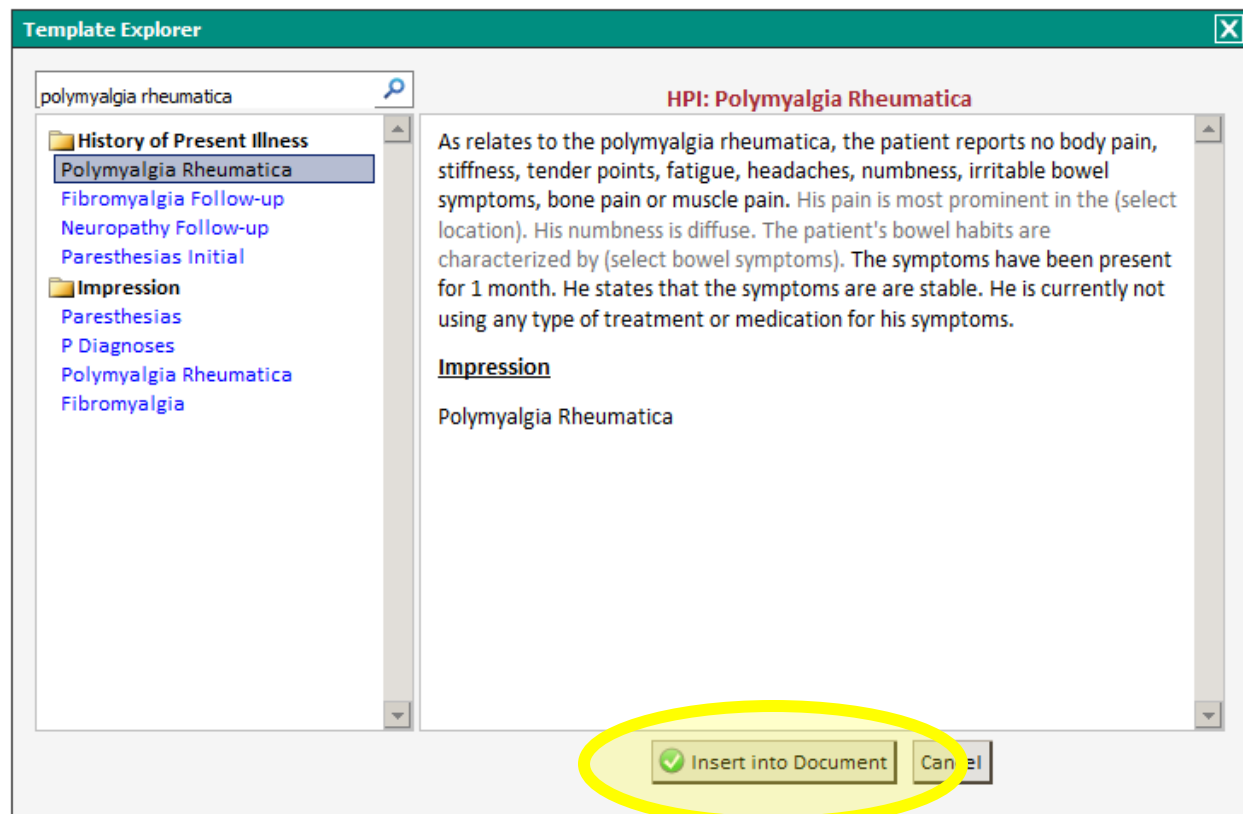


Searching the Template Database

To search the database for a desired template, enter the desired search term in the search box which is found above the template map.



This will search the entire template database for all mentions of the search term.



The Template Explorer displays each instance that the search term is used in the Clicktate™ system and allows the paragraph to be placed into a template if desired.

The Menu Bar

The Menu Bar is the control panel for the Clicktate console.



The functions found on the Menu Bar Include:

- **New**- Opens the New document creation pop-up which allows users to select template type, specific note type, and date of service.

A screenshot of the 'Create New Document' dialog box. The title bar is green with a close button. The main area is light gray. At the top, there's a text field containing 'Test, Darla' and a 'Choose another' link with a person icon. Below this, there are three rows of controls: 'Date of Service' with a date field showing '27-Apr-2012' and a calendar icon; 'Send To' with a dropdown menu and a 'Set as default' link; and 'Template' with a dropdown menu showing 'Medical Note' and a 'Set as default' link. Below these are three large, light gray buttons: 'Blank Medical Note' (with a document icon), 'Replicate from Patient History' (with a document icon and 'Medical Note DOS: 27-Apr-2012' text), and 'Apply Custom Template:' (with a document icon and a dropdown menu showing 'cad patient (Medical Note)'). At the bottom center is a 'Cancel' button.

- **Open**- Opens a list of previously created documents for the patient allowing the user to review previous notes.

The 'Patient History' window displays a list of medical notes for 'Test, Darla'. The window has a title bar with a close button. Below the patient name, there is a 'Choose another' link with a person icon. The list contains five entries, each with a date, a document type, and an update timestamp. The first entry is highlighted in blue.

Date	Document Type	Updated
11-May-2012	Medical Note	Updated: Today, 12:42PM
27-Apr-2012	Medical Note	Updated: 27-Apr-2012, 3:26PM
11-Aug-2009	Discharge Letter	Updated: 11-Aug-2009, 6:30PM
11-Aug-2009	Discharge Letter	Updated: 11-Aug-2009, 6:28PM
11-Aug-2009	Discharge Letter	

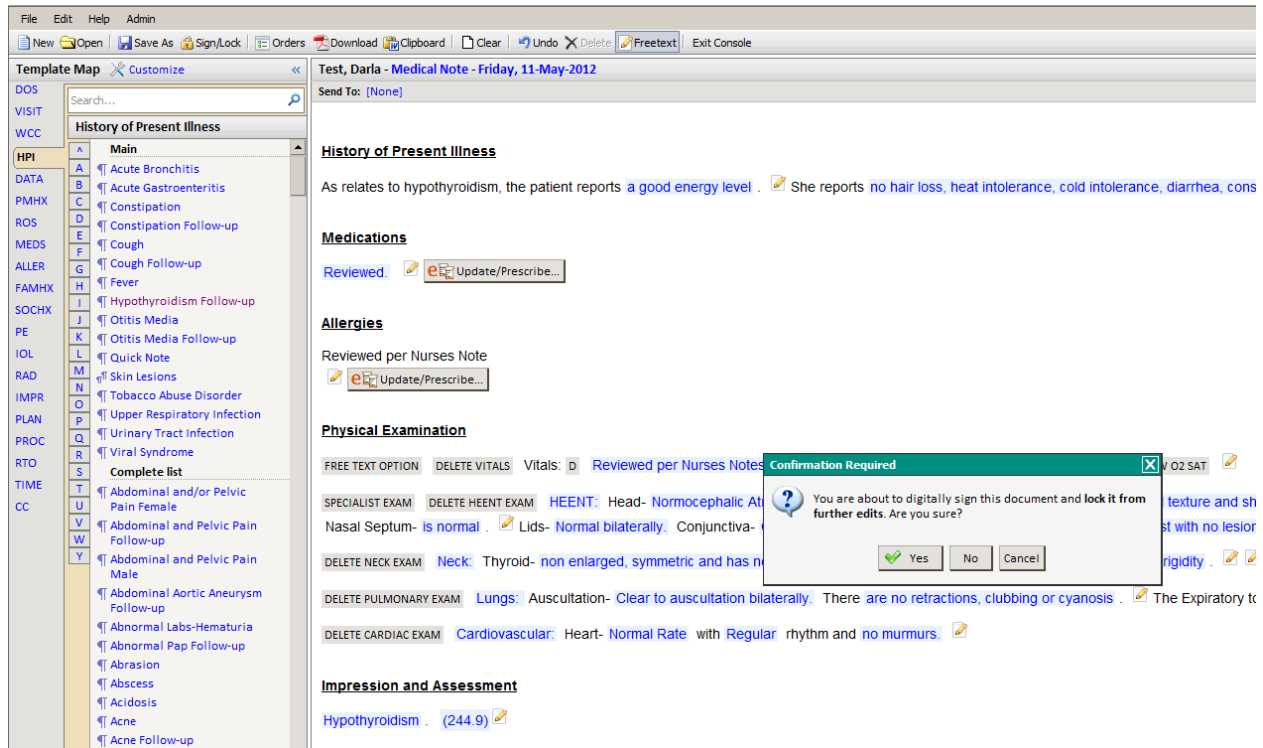
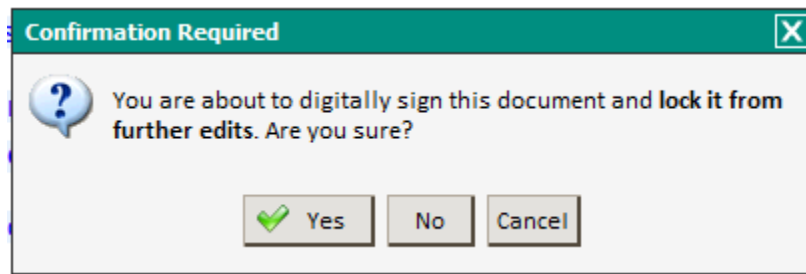
A 'Cancel' button is located at the bottom right of the window.

- **Save As**- Saves a note in a format that allows the note to be re-opened, reviewed and changed later and also allows the user to assign a name to a note. This function allows users to specify that this note is to be the standard template note for a patient and therefore sets the note as the default “to replicate” note.

It should be noted that Clicktate utilizes an AUTOMATIC SAVE FEATURE. It is not necessary to “Save” a note when it is created. The purpose of the “Save As” feature is to allow users to change note attributes such as name and date of service, or to allow specification as a standard note to replicate.

The 'Save Note As' window is used to save a new note for 'Test, Darla'. It includes a title bar with a close button. The patient name is displayed in a text box. Below this, there is a 'Label' field with 'Medical Note' and a 'Date of Service' field with '11-May-2012' and a calendar icon. A checkbox labeled 'Use as patient's standard Medical Note' is present and unchecked. At the bottom, there are 'Save Note' and 'Cancel' buttons.

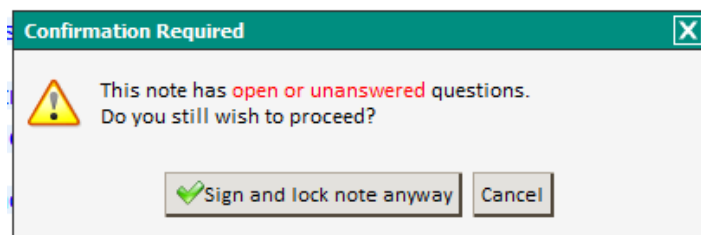
- **Sign/ Lock-** Signs and locks a document in a permanent form, preventing further changes.



Selecting "Yes" results in a signed and locked document.

Once a Document is Signed and Locked, the functions on the menu bar which allow document changes are no longer active. The document can still be downloaded and copied to the clipboard.

Attempting to Download, Sign and Lock or use the Save As feature on a note that has "open" or unanswered questions will result in a warning message to remind the user to complete the note prior to utilizing the above features.



- **Orders-** Sends patient orders to the Computerized Order Entry (CPOE) and Tracking System thereby allowing users to save and track orders as they are entered into a note. This is explained in detail in the Order Entry and Tracking section of this manual.
- **Download-** Downloads a note to Adobe Acrobat Reader. Click the open button to open the document. If you desire to print out a document, you may do so from Adobe Acrobat by pressing the DOWNLOAD button at the top of the console. When the Download button is activated, a dialogue box will appear to ask if you would like to Save or Open the Document.

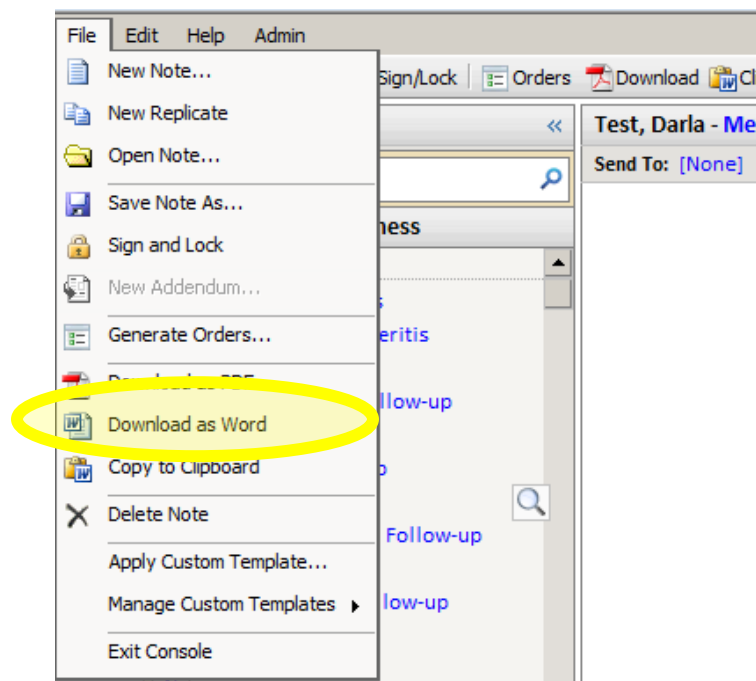
To Open the Document to Acrobat, Press the Open button. The appropriate Header and Footer will appear on your document automatically. This includes the patient's birthday, page number, physician name and date of service.

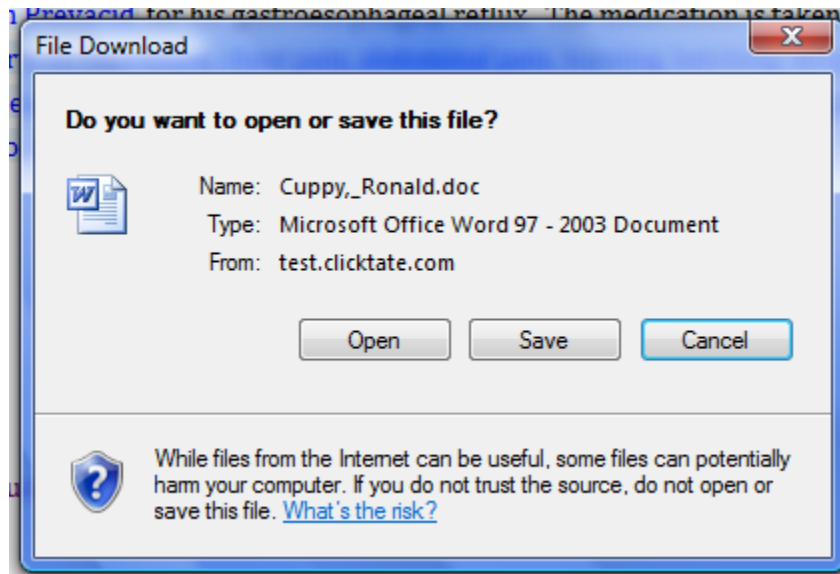
Both notes that either open or signed/locked may be opened from the menu bar in Adobe Acrobat.

IMPORTANT NOTE: PRIOR TO SAVING ANY NOTES OR PATIENT DATA ON A PERSONAL COMPUTER, IT IS IMPORTANT TO ENSURE ADEQUATE SAFETY PROCESSES INCLUDING PASSWORD PROTECTION, ENCRYPTION, AND ADEQUATE VIRUS PROTECTION AND FIREWALLS ARE IN PLACE. AS ALWAYS, YOUR DATA AND DATA REGARDING PATIENTS IS SECURE WHEN SAVED ON THE HIPAA COMPLIANT CLICKTATE® SYSTEM.

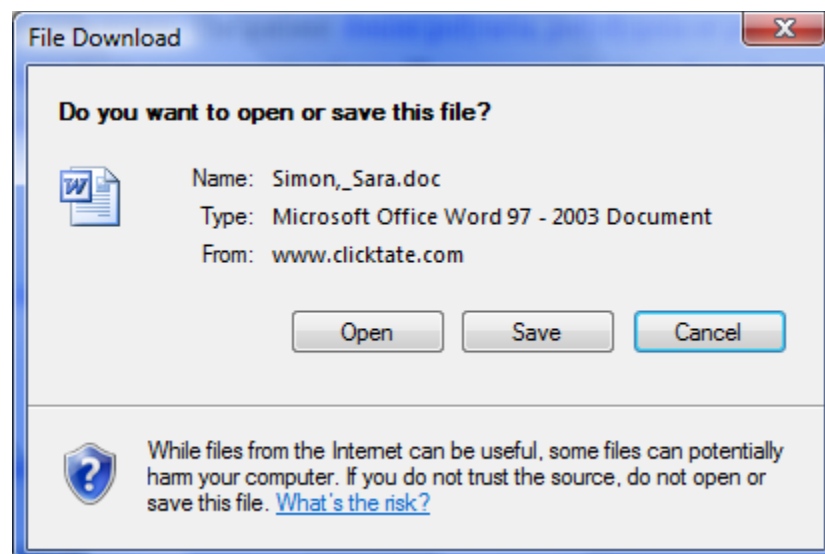
If a user desires to open a note in Microsoft Word, this may be accomplished from the File Menu which is found in the upper left corner of the Console. Open the file menu and select "Download as Word" from the Menu.

ONLY UNSIGNED AND NON-LOCKED DOCUMENTS MAY BE OPENED IN MICROSOFT WORD.





When the dialogue box appears, do NOT save the document to non-secure computers. Clicktate® can NOT be responsible for the security of documents that you choose to save on computers. We recommend that documents only be saved to secure, HIPAA compliant computers.

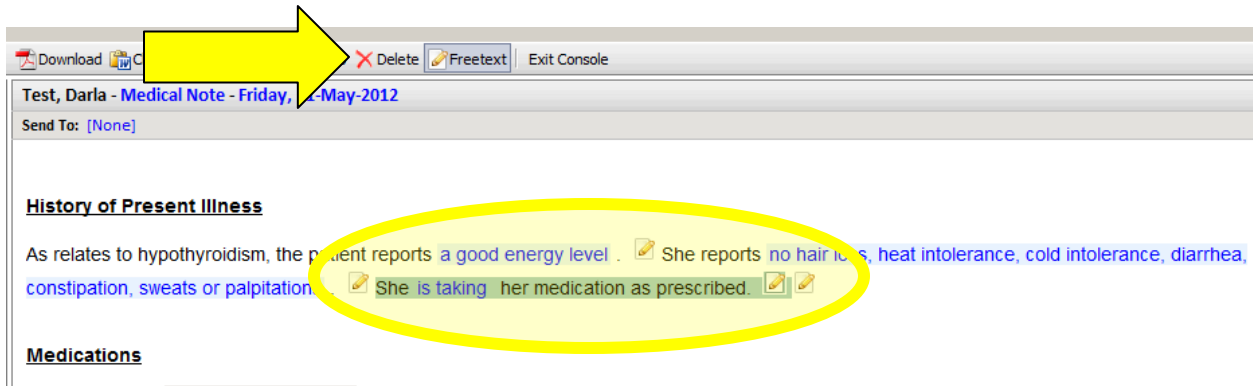


- **Clipboard**- Copies a note onto the computer clipboard where it can be pasted into any system that accepts pasted documents.

Documents that are on the clipboard may be pasted into another program by using CTRL V or the Paste function in the computers top menu bar.

- **Clear**- Clears the document and allows the user to “start over”.

- **Undo**- Reverses the last action taken. To reverse further actions, continuing to press the undo button will reverse actions sequentially starting from the most recent.
- **Delete**- Deletes text that is selected from a document. To delete a section of text, select and highlight the section to delete and then press the “Delete” button.



- **Freetext**- Allows the insertion of free text into a document.

History of Present Illness

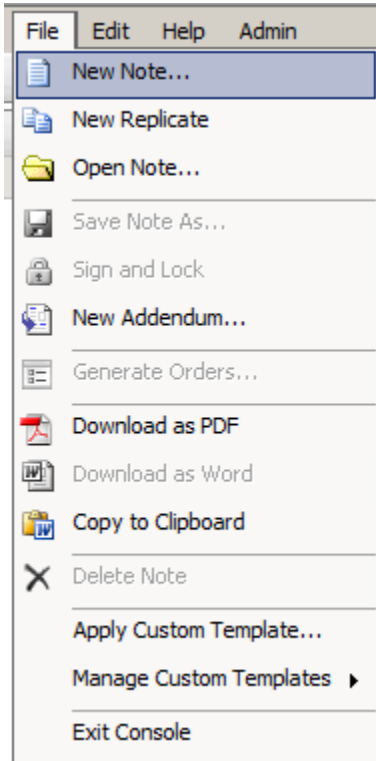
The patient is on Prevacid for his gastroesophageal reflux. The medication is taken on a regular basis. He requires no other treatments for his GERD. He reports no heartburn, chest pain, abdominal pain, burning, belching, dysphagia, unexplained weight loss, rectal bleeding, nausea, vomiting, diarrhea, odynophagia or early satiety. The GERD has no known aggravating factors. There is no family history of Barrett's esophagus or esophageal cancer. The patient has never had an EGD.

- **Exit Console**- Exits the console and returns to the last page opened prior to entering the note generation console.
- **Addendum**- This toggle only appears for notes that are Signed and Locked. It allows the addition of a Dated and Time Stamped addendum to a signed and locked note.

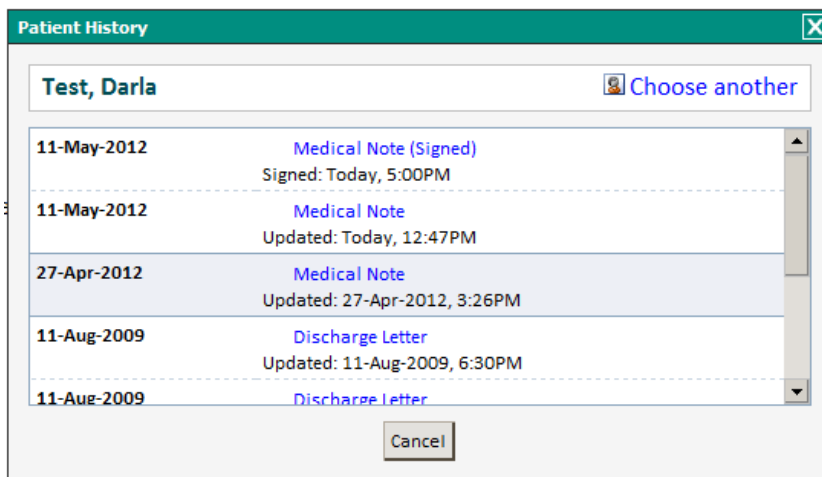


File Menu Dropdown

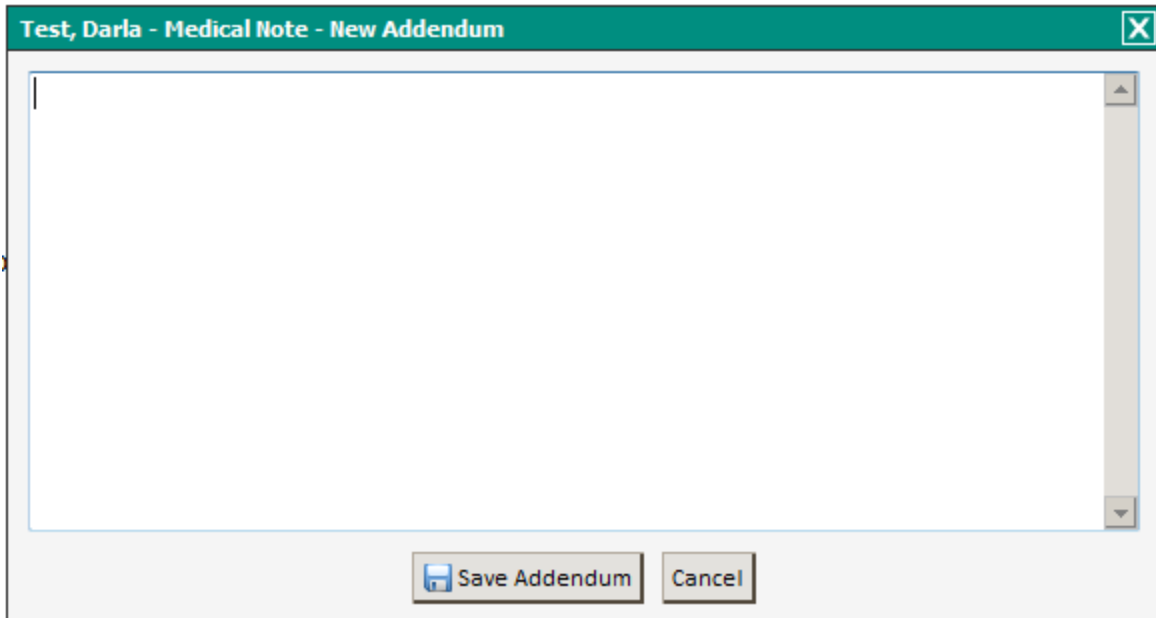
Functions include many of the same functions found on the menu bar including New Note, Open Note, Save Note, Sign and Lock, New Addendum, Generate Orders, Download as PDF, Download to Word, Copy to Clipboard, Apply Custom Template, Manage Custom Templates and Exit Console.



- **New Note-** Allows a new note to be started from the console.
- **New Replicate-** Allows the note on the screen to be replicated as a New Note.
- **Open Note-** Opens the patient note menu so that previously created notes may be reviewed.



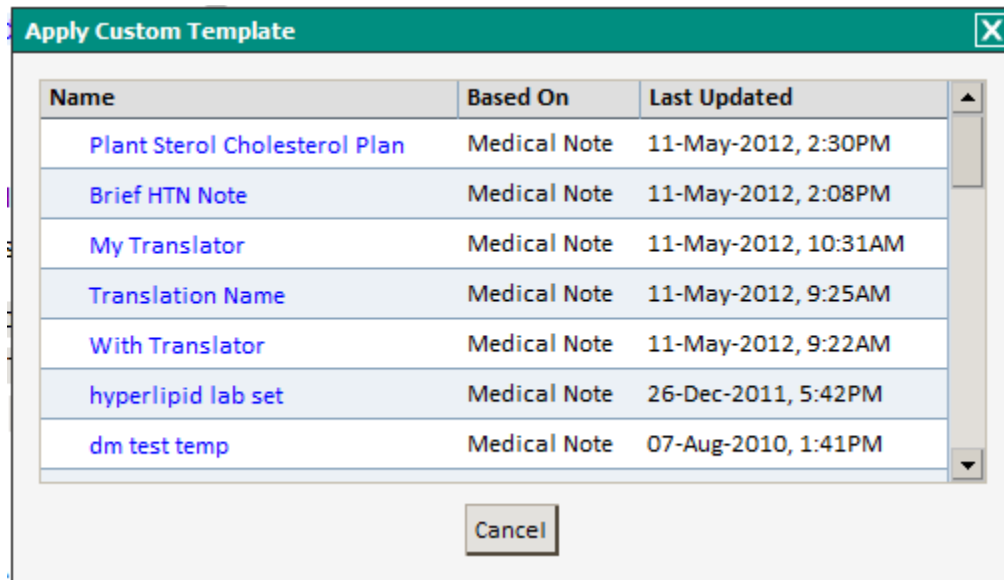
- **Save Note As-** Allows a note to be saved with an alternate name or date of service.
- **Sign and Lock-** Allows a note to be signed and locked and prevents further changes.
- **New Addendum-** Allows an addendum to be added to a note that has been signed and locked.



The screenshot shows a window with a teal title bar that reads "Test, Darla - Medical Note - New Addendum". Inside the window is a large, empty white rectangular area for text entry. At the bottom of the window, there are two buttons: "Save Addendum" with a floppy disk icon and "Cancel".

- **Generate Orders-** Sends patient orders to the Computerized Order Entry (CPOE) and Tracking System thereby allowing users to save and track orders as they are entered into a note. This is explained in detail in the Order Entry and Tracking section of this manual.
- **Download as PDF-** Copies a note to Adobe Acrobat so that it may be printed.
- **Download as Word-** Copies a note to Microsoft® Word so that it may be printed. This function is only available for notes that are NOT signed and locked.
- **Copy to Clipboard-** Copies a note to the computer clipboard where it may be pasted into another document.
- **Delete Note-** Allows the user to delete an unsigned note. A warning prompt will appear prior to this action being taken. **THIS ACTION RESULTS IN PERMANENT NOTE REMOVAL AND IS NOT REVERSIBLE.**

- **Apply Custom Template**- Allows user defined templates to be brought into open (unsigned) notes on the console.

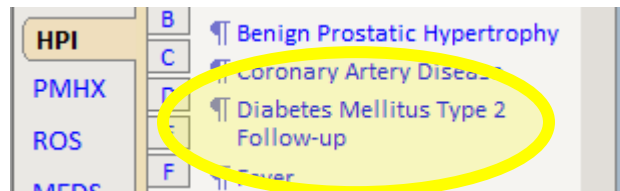
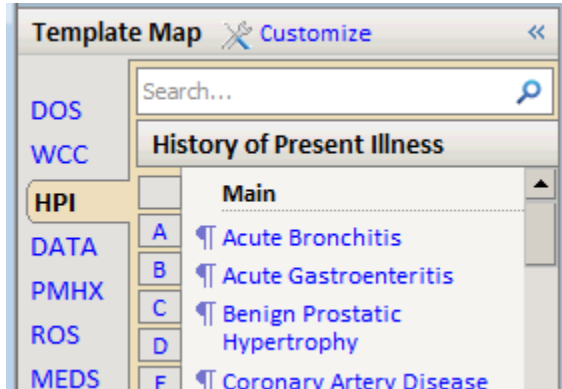


- **Manage Custom Templates**- Discussed in detail in the Custom Template Section of the manual.

Generating a Note

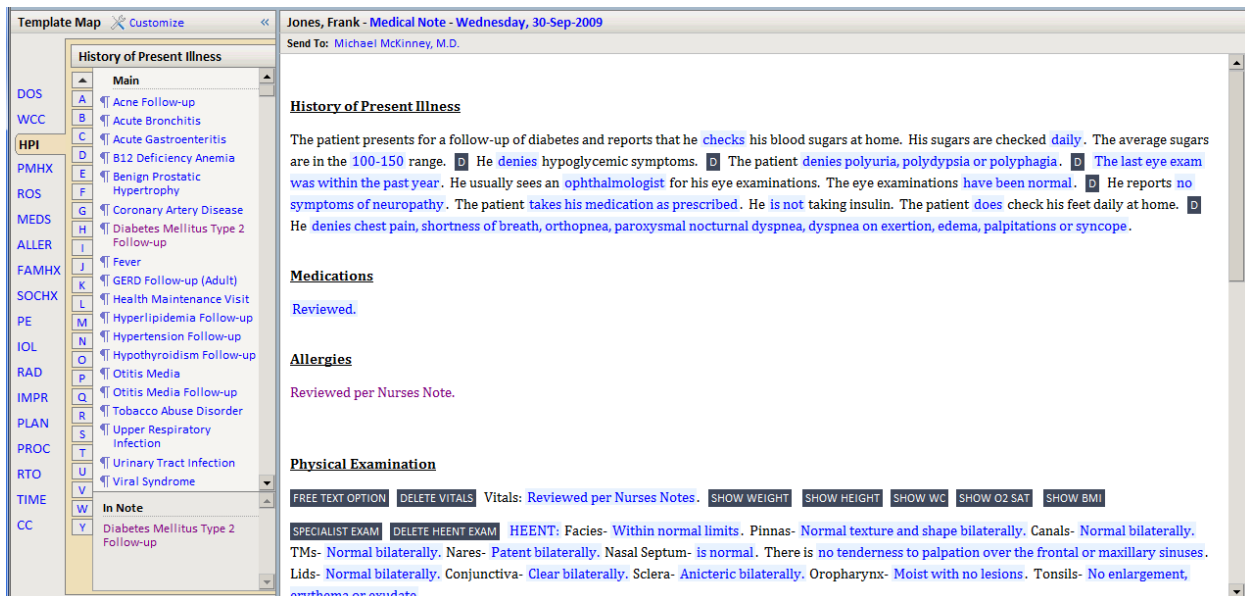
To generate a medical note, select the appropriate disease or symptom. A good starting point is usually the HPI section, but this is not always the case. To start a note, let's generate a note for a diabetes follow-up visit.

First, from the patient console Template Map, under the HPI Section, and the MAIN tab:

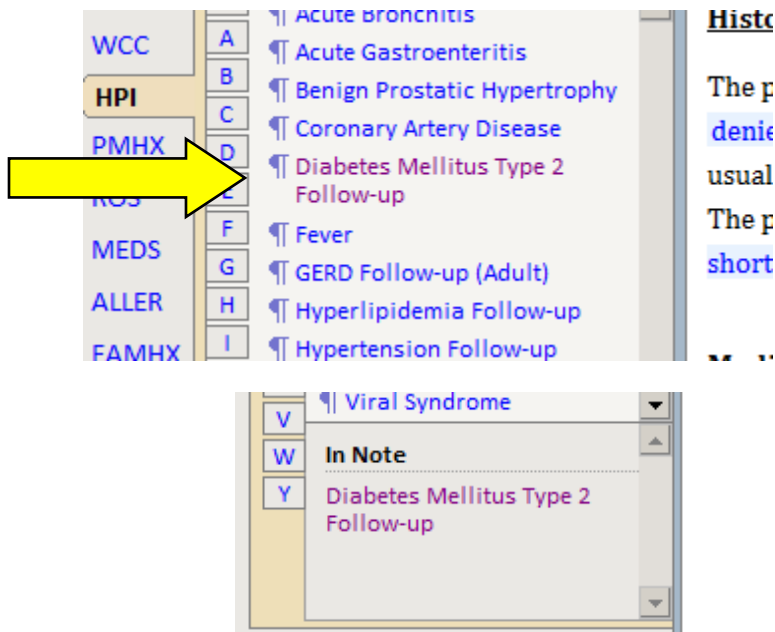


Select Diabetes Mellitus Type 2 Follow-up:

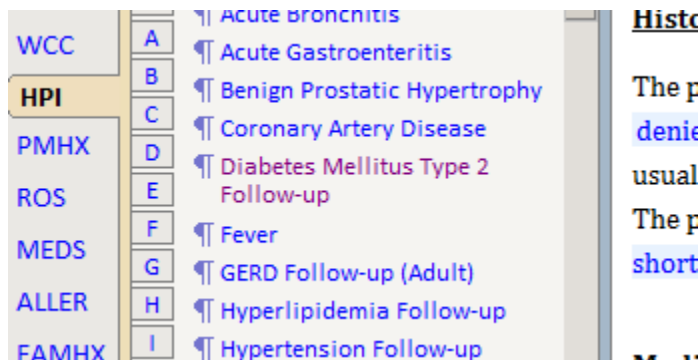
The Diabetes Note template will appear.



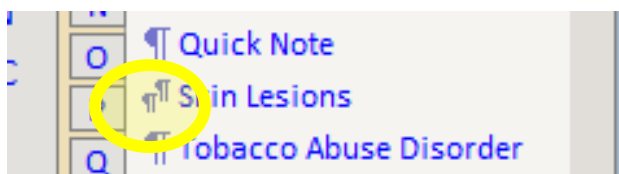
The selected paragraph indicators will change color to indicate which paragraph has been chosen. In addition, paragraphs found in a note will appear in the “In Note” section found at the bottom of the template map.



Selecting an additional diagnosis or problem will add additional information to the note. Clicktate is designed to minimize repetition within notes. Therefore, if chest pain appears in one paragraph, it will not appear in a subsequent paragraph. In this example, we will add Coronary Artery Disease to the note by selecting it.



Any option in the template map that is included in the note will appear in purple in the template map. Re-clicking an included (purple) option will remove it from the note.



NOTE: Some paragraphs are denoted by a double paragraph symbol.

These paragraphs are repeatable and may be inserted into a note multiple times. To remove these paragraphs from a note, deselect them from the In Note section at the bottom of the template map.

The note will now contain paragraphs related to the patient's Diabetes and Coronary Artery Disease.

Jones, Frank - Medical Note - Wednesday, 30-Sep-2009
Send To: Michael McKinney, M.D.

History of Present Illness

The patient presents for a follow-up of diabetes and reports that he checks his blood sugars at home. His sugars are checked daily. The average sugars are in the 100-150 range. D He denies hypoglycemic symptoms. D The patient denies polyuria, polydypsia or polyphagia. D The last eye exam was within the past year. He usually sees an ophthalmologist for his eye examinations. The eye examinations have been normal. D He reports no symptoms of neuropathy. The patient takes his medication as prescribed. He is not taking insulin. The patient does check his feet daily at home. D He denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

As relates to the patient's Coronary Artery Disease, he denies diaphoresis. D The patient reports that he is diabetic but he is not a smoker, hypertensive or hyperlipidemic. SHOW Prior Cardiac Interventions He takes an aspirin daily.

Medications

Reviewed.

Since chest pain is mentioned in the Diabetes paragraph it will not be repeated in the Coronary Artery Disease paragraph. Also note that the system recognizes that the patient is diabetic and automatically includes diabetes as a risk factor in the Coronary Artery Disease paragraph.

From within a note, any of the BLUE highlighted phrases may be Clicktated to select other options; this will also make other changes in the note. For instance, if you select the phrase "no murmurs" under the cardiac exam, a pop-up containing other options will appear.

DELETE PULMONARY EXAM Lungs: Auscultation- Clear to auscultation bilaterally. There are no retractions, clubbing or crackles. The Expiratory u
Inspiratory ratio is equal.

DELETE CARDIAC EXAM Cardiovascular: There are no carotid bruits. Heart- Normal Rate with Regular rhythm and no murmurs. There are no
gallops. There are no rubs. In the lower extremities there is no edema. The upper extremities do not have edema.

DELETE ABDOMEN EXAM Abdomen: Soft, benign, non-tender with no masses, hernias, organomegaly or scars.

CLICK HERE TO DELETE FOOT EXAM Feet: The feet are symmetric with normal boney landmarks. There is no tenderness to palpation bilaterally. The

DELETE NECK EXAM Neck: Thyroid- non enlarged, symmetric and has no nodules or bruits. ROM- Normal Range of Motion with no rigi

DELETE PULMONARY EXAM Lungs: Auscultation- Clear to auscultation bilaterally. The
Inspiratory ratio is equal.

DELETE CARDIAC EXAM Cardiovascular: Heart- Normal Rate with Regular rhythm an

SHOW PULSES OR ADD PULSE TABLE

DELETE ABDOMEN EXAM Abdomen: Soft, benign, non-tender with no masses, hernias,
SHOW ABDOMINAL BRUIT

CLICK HERE TO DELETE FOOT EXAM Feet: The feet are symmetric with normal boney la
have normal posterior tibial and dorsalis pedis pulses and normal capillary refill bil

The arches are normal bilaterally. There are no skin/nail lesions present. There a

CardioVascular Heart Murmur

none	1/6 systolic	2/6 systolic
3/6 systolic	4/6 systolic	5/6 systolic
6/6 systolic	1/4 diastolic	2/4 diastolic
3/4 diastolic	4/4 diastolic	
other		
Insert Free Text		

he Cardiovascular Heart Murmur

none	1/6 systolic	2/6 systolic
3/6 systolic	4/6 systolic	5/6 systolic
6/6 systolic	1/4 diastolic	2/4 diastolic
3/4 diastolic	4/4 diastolic	

other

Insert Free Text

By selecting one of these options, the note will be appropriately changed. You will also notice that Heart Murmur now appears in the Impression and Plan.

Impression and Plan

DELETE CARDIAC EXAM Cardiovascular: There are no carotid bruits. Heart- Normal Rate with Regular rhythm and a 3/6 crescendo/decrescendo systolic murmur heard loudest over the entire precordium with no radiation. There are no gallops. There are no rubs. In the lower extremities there is no edema. The upper extremities do not have edema.

DELETE ABDOMEN EXAM Abdomen: Soft, benign, non-tender with no masses, hernias, organomegaly or scars.

CLICK HERE TO DELETE FOOT EXAM Feet: The feet are symmetric with normal boney landmarks. There is no tenderness to palpation bilaterally. The feet have normal posterior tibial and dorsalis pedis pulses and normal capillary refill bilaterally. The monofilament examination is normal bilaterally.

The arches are normal bilaterally. There are no skin/nail lesions present. There are no ingrown nails. There are no bunions noted.

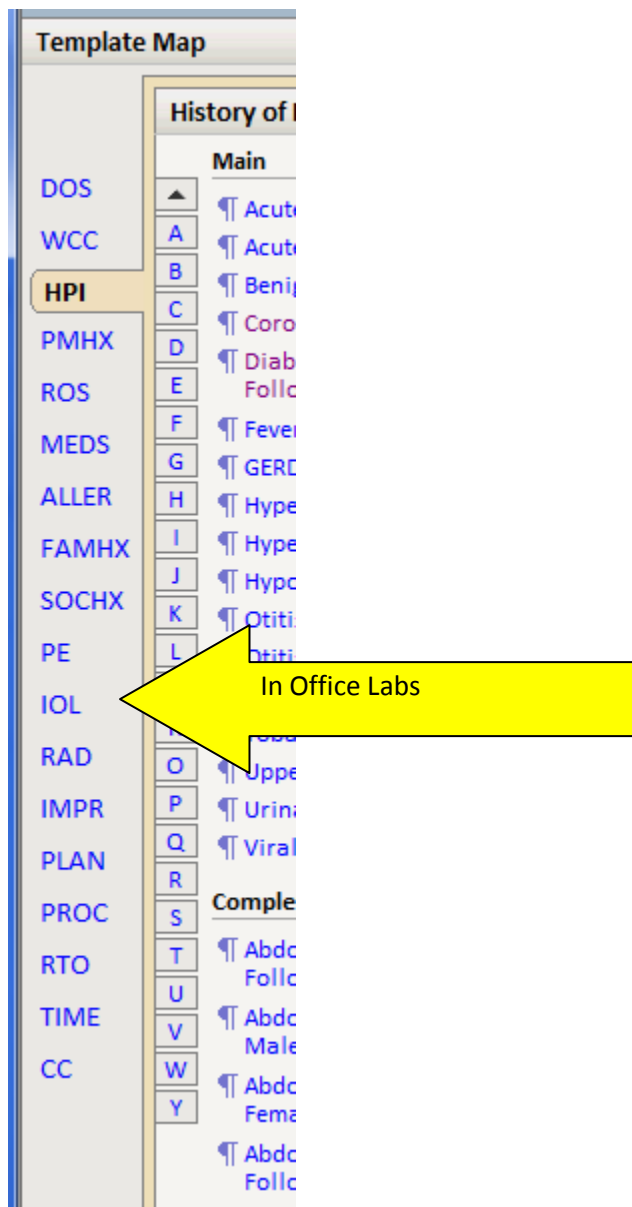
Impression and Assessment

DM-2 controlled.

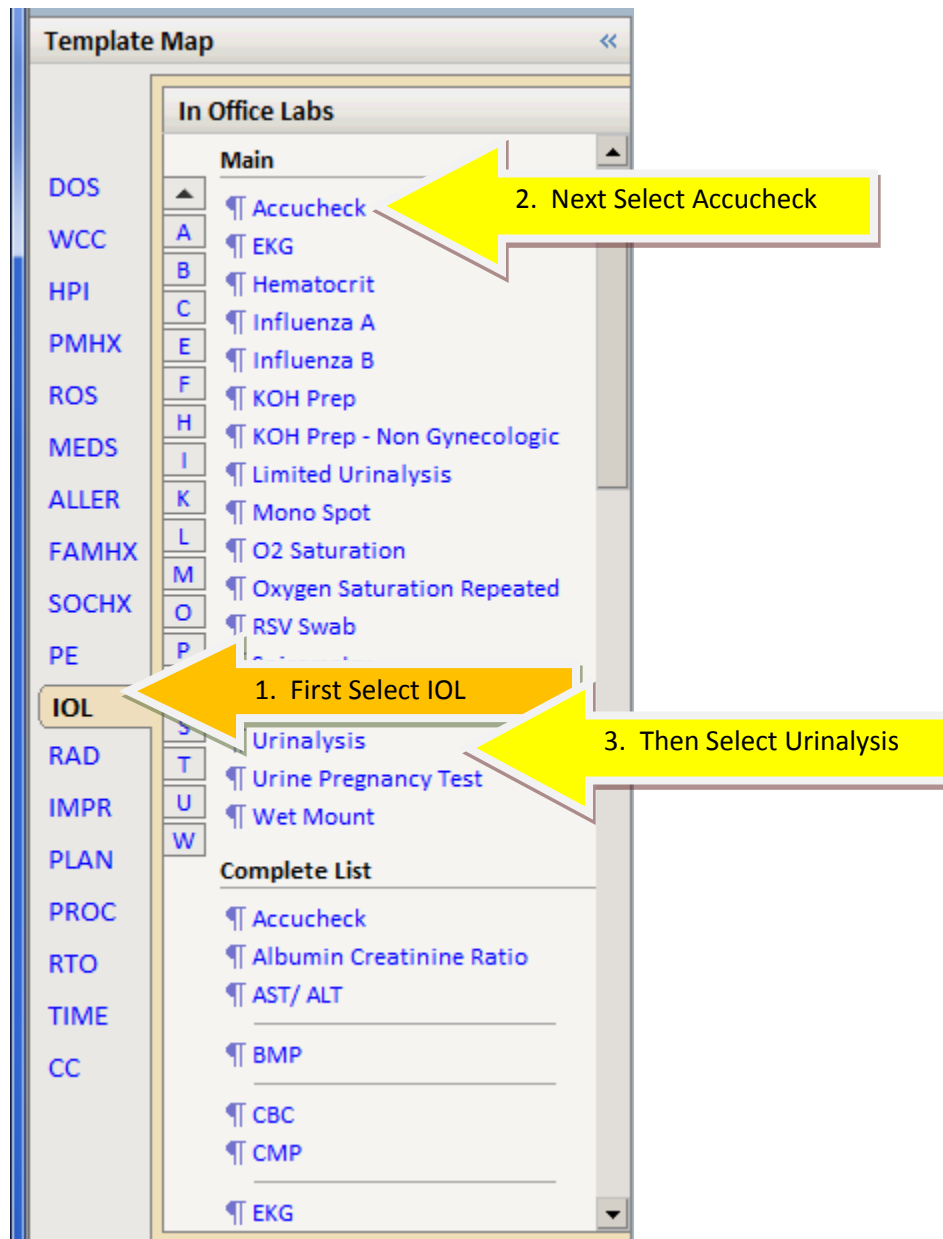
Coronary Artery Disease.

Systolic Heart Murmur

Other options may be added as appropriate, including other diagnoses or symptoms, labs, X-rays, impressions and even multiple plans for different diseases. In the above example, to add a Urinalysis and Accucheck, select IOL from the Template Map Menu.



Then select Urinalysis and Accucheck from the Paragraph Menu.



Accucheck and Urinalysis will now appear in your document.

The arches are normal bilaterally. There are no skin/nail lesions present. There are no ingrown nails. There are no bunions noted.

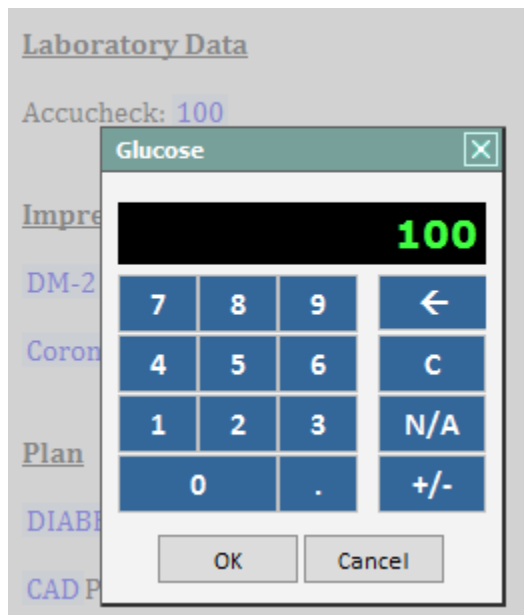
Laboratory Data

Accucheck: 100

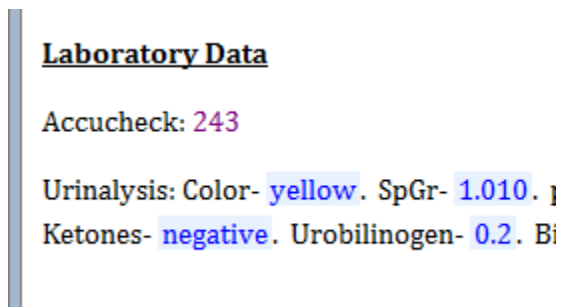
Urinalysis: Color- yellow, SpGr- 1.010, pH- 5.0, Leukocyte Esterase- negative, Nitrite- negative, Protein- negative, Glucose- negative, Ketones- negative, Urobilinogen- 0.2, Bilirubin- negative, Blood- negative.

Impression and Assessment

To change the Accucheck value, click on the 100 (in blue). A number box will appear.



Input the correct value and click OK. It will appear in your document. In this case let's change the value to 243.



You will see that the value has changed to 243 in your document.

The Plan section of the note will list a plan for each separate disease process. Click on the blue options i.e. (diabetes options), (heart murmur options) to input your plan.

Plan

DIABETES PLAN: (diabetes options).

CAD PLAN: (cad options).

HEART MURMUR PLAN: (heart murmur options).

COMMON CHEMISTRIES HEME TESTS ONCOLOGY ENDOCRINE TESTS RHEUMATOLOGY TESTS INFECTIOUS DISEASE TESTS
CARDIOLOGY TESTS GI TESTS RENAL TESTS URINE TESTS ULTRASOUND CT SCANS MRI SCANS MISCELLANEOUS TESTS
REFERRALS TREATMENT

Add: Add Med

Discontinue: Discontinue Med

Refilled: Refill Med

By selecting the blue (diabetes options) choice a pop-up box will appear with disease process specific items.

Endocrinology Plan

Select

Continue Current

Med Change

Med Added

Hospital

Stable

Further Plans After Tests

Further Plans Next Visit

Endocrinology and Metabolism Plan:

☐ Alcohol Decrease

☐ Alcohol Discontinue

☐ Bariatric Follow-up

☐ Bariatric Referral

☐ Calcium 1000 mg Daily

☐ Calcium 1200 mg Daily

☐ Calcium 1500 mg Daily

☐ Calcium 2000 mg Daily

☐ Calcium 400 mg Daily

☐ Calcium 600 mg Daily

☐ Calcium 800 mg Daily

☐ Dairy Decrease

☐ Dairy Discontinue

☐ Dev Peds Follow-up

☐ Dev Peds Referral

☐ Diabetic Education

☐ Diabetic Insulin Teaching

☐ Diet AHA

☐ Diet Low Fat

☐ Diet Low Salt

☐ Diet- 1000 cal ADA

☐ other

☐ Diet- 1200 cal ADA

☐ Diet- 1500 cal ADA

☐ Diet- 1800 cal ADA

☐ Diet- 2000 cal ADA

☐ Dietician Follow-up

☐ Dietician Referral

☐ Endocrine Follow-up

☐ Endocrine Referral

☐ ENT Follow-up

☐ ENT Referral

☐ Exercise

☐ Exercise Aerobic Daily

☐ Exercise Wt Bearing

☐ Exercise Wt Lift 3x week

☐ Fluid Restrict 1000 mL

☐ Fluid Restrict 1500 mL

☐ Fluid Restrict 2000 mL

☐ GI Follow-up

☐ GI Referral

☐ Genetics Referral- Fam

☐ Genetics Referral- Pt

☐ Gym Membership Recom

☐ Home Glucose AC HS

☐ Home Glucose BID

☐ Home Glucose Daily

☐ Home Glucose TID

☐ Hospital Admit

☐ Increase Fiber

☐ Increase Fluids

☐ Metabolism Follow-up

☐ Metabolism Referral

☐ Monitor Closely

☐ Nephrology Follow-up

☐ Nephrology Referral

☐ Nutrition Follow-up

☐ Nutrition Referral

☐ Oncology Follow-up

☐ Oncology Referral

☐ Ophthalmology Follow-up

☐ Ophthalmology Referral

☐ Personal Trainer

☐ Plastics Follow-up

☐ Plastics Referral

☐ Probiotics

☐ Surgery Follow-up

☐ Surgery Referral

☐ Urology Follow-up

☐ Urology Referral

☐ Vitamin D 1000 U Daily

☐ Vitamin D 1200 U Daily

☐ Vitamin D 1500 U Daily

☐ Vitamin D 2000 U Daily

☐ Vitamin D 400 U Daily

☐ Vitamin D 800 U Daily

☐ Wt Loss Recommended

☐ Wt Loss Clinic Follow-up

☐ Wt Loss Clinic Referral

☐ Wt Watchers Recommend

☐ Continue Meds

☐ Adjust Meds

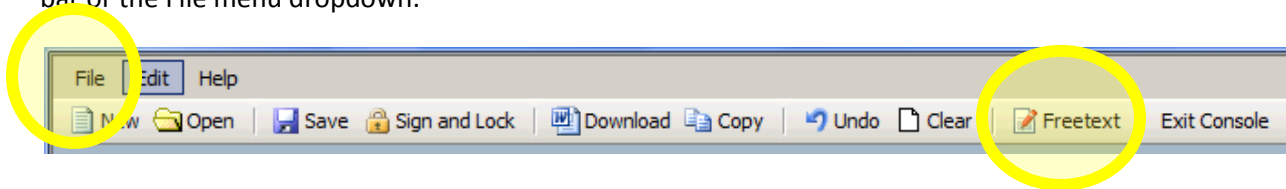
☐ Add Med

Apply Checkmarked

The green boxes at the top are SINGLE SELECTION BOXES, checking these boxes will close the window and input the selection with no further action. The smaller check boxes at the bottom are MULTI SELECTION BOXES where multiple selections may be chosen. Click the “apply checkmarked” button when you have made the appropriate selections. The “other” box at the bottom may be used to input items not found in the other multi or single choice options.

The Free Text Box

Because we realize that it is not possible to anticipate every scenario that a patient may report, we have included a free text option. To turn on the Free Text Option, select the Free Text button from the menu bar or the File menu dropdown.



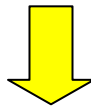
In the current example, if the patient is taking insulin but it makes him very nervous, the anxiety will need to be documented. In the first paragraph of our note, let's input that she is taking insulin.

History of Present Illness

The patient reports that he checks his blood sugars at home. His sugars are checked daily. The average sugars are in the 100-150 range. [D] He denies hypoglycemic symptoms. [D] The patient denies polyuria, polydipsia or polyphagia. [D] The last eye exam was within the past year. He usually sees an ophthalmologist for his eye examinations. The eye examinations have been normal. [D] He reports no symptoms of neuropathy. The patient takes his medication as prescribed. He is not taking insulin. [D] He denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

Click on "is not"

As relates to the patient's Coronary Artery Disease, he denies diaphoresis. [D] The patient reports that he is diabetic but he is not a smoker, hypertensive or hyperlipidemic. [SHOW Prior Cardiac Interventions] He takes an aspirin daily.



History of Present Illness

The patient reports that he checks his blood sugars at home. His sugars are checked daily. The average sugars are in the 100-150 range. [D] He denies hypoglycemic symptoms. [D] The patient denies polyuria, polydipsia or polyphagia. [D] The last eye exam was within the past year. He usually sees an ophthalmologist for his eye examination. The eye examinations have been normal. [D] He reports no symptoms of neuropathy. The patient takes his medication as prescribed. He is taking insulin. [DELETE INSULIN TABLE] His injection sites are rotated appropriately. The patient does check his feet daily at home. [D] He denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

Based on this change, additional information will appear in the note. To add additional free text, click on the Free Text button in the menu bar.

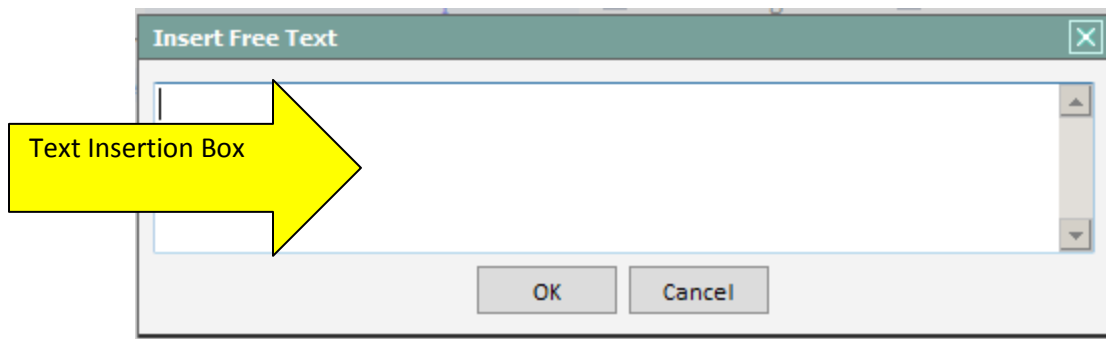
A series of Free Text toggles appear. Free text can be inserted by clicking on any of these boxes at the appropriate point. Let's click the FT box that is after the "He is taking insulin" sentence.

History of Present Illness

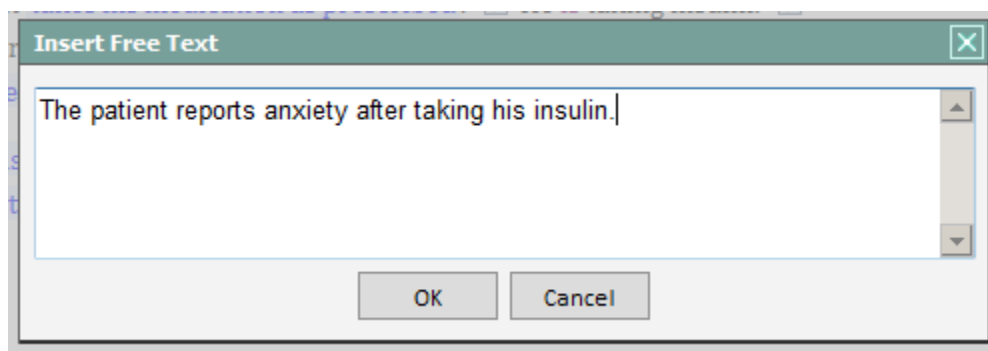
The patient reports that he checks his blood sugars at home. [X] His sugars are checked daily. [X] The average sugars are in the 100-150 range. [X] [D] He denies hypoglycemic symptoms. [X] [D] The patient denies polyuria, polydipsia or polyphagia. [X] [D] The last eye exam was within the past year. [X] He usually sees an ophthalmologist for his eye examinations. [X] The eye examinations have been normal. [X] [D] He reports no symptoms of neuropathy. [X] The patient takes his medication as prescribed. [X] He is taking insulin. [X] [DELETE INSULIN TABLE] His injection sites are rotated appropriately. [X] The patient does check his feet daily at home. [X] [D] He denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope. [X]

As relates to the patient's Coronary Artery Disease, he denies diaphoresis. [X] [D] The patient reports that he is diabetic but he is not a smoker, hypertensive or hyperlipidemic. [X] [SHOW Prior Cardiac Interventions] He takes an aspirin daily. [X]

A Text Insertion Box will appear.



Free text can now be inserted.



Click OK and the Free Text will be inserted into the document.

The last eye exam was within the past year. He usually sees an ophthalmologist for his eye examinations. The eye examinations have been normal. He reports no symptoms of neuropathy. The patient takes his medication as prescribed. He is taking insulin. The patient reports anxiety after taking his insulin. DELETE INSULIN TABLE His injection sites are rotated appropriately. The patient does check his feet daily at home. He denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

The Free Text will be highlighted in yellow, making it easier to recognize. You may change, add to, or delete the free text by clicking on the highlighted area.

To turn off or hide free text toggles, click the free text button on the menu bar. When the toggles are turned off, any free text that you have added to your document will be retained and remain visible.

Options for Deleting Text from Clicktate

There are several options for deleting unwanted or unneeded text from Clicktate notes.

- Delete Toggles
- Paragraph Removal
- Highlight and Delete
- Double Clicking Options from within Multi-option Pop-ups
- Removing Physical Exam Options by Selecting the Section Title

Delete Toggles

Clicktate documents also contain delete toggles to remove unwanted text from a document. The delete toggles are denoted by a small blue D or by a more descriptive blue delete box.

History of Present Illness

The patient reports that he **checks** his blood sugars at home. His sugars are checked **daily**. The average sugars are in the **100-150** range. **D** He **denies** hypoglycemic symptoms. **D** The patient **denies polyuria, polydypsia or polyphagia**. **D** The last eye exam was within the past year. He sees an **ophthalmologist** for his eye examinations. The eye examinations have been normal. **D** He reports **no symptoms of neuropathy**. The patient **takes his medication as prescribed**. He is taking insulin. The patient reports anxiety after taking his insulin. **DELETE INSULIN TABLE** His injection sites **are** rotated appropriately. The patient **does** check his feet daily at home. **D** He **denies** chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

As relates to the patient's Coronary Artery Disease, he **denies diaphoresis**. **D** The patient reports that he is **diabetic** but he is not a **smoker**, **hypertensive or hyperlipidemic**. **SHOW Prior Cardiac Interventions** He **takes an aspirin daily**.

The delete toggles remove the sentence **immediately following the toggle**. Clicking on the highlighted D above will remove the eye exam sentence.

History of Present Illness

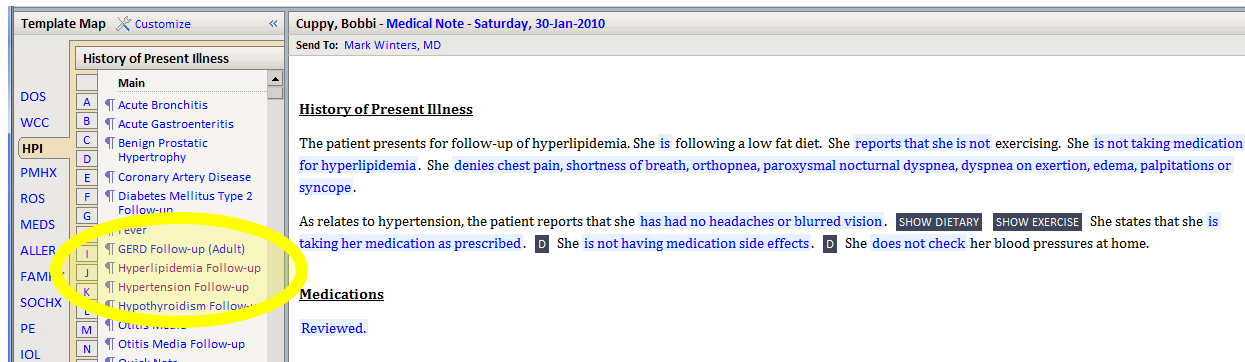
The patient reports that he **checks** his blood sugars at home. His sugars are checked **daily**. The average sugars are in the **100-150** range. **D** He **denies** hypoglycemic symptoms. **D** The patient **denies polyuria, polydypsia or polyphagia**. **SHOW EYE EXAM** **D** He reports **no symptoms of neuropathy**. The patient **takes his medication as prescribed**. He is taking insulin. The patient reports anxiety after taking his insulin. **DELETE INSULIN TABLE** His injection sites **are** rotated appropriately. The patient **does** check his feet daily at home. **D** He **denies** chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

A new toggle will appear allowing reinsertion of the eye exam if it is needed.

The more descriptive delete toggles will remove items from the document that do not immediately follow the toggle. The DELETE INSULIN TABLE toggle above will delete the insulin table which is found in the medication section of the document.

Paragraph Removal

Paragraphs that were inserted and need to be removed may be removed by re-clicking on the paragraph name in the template map.

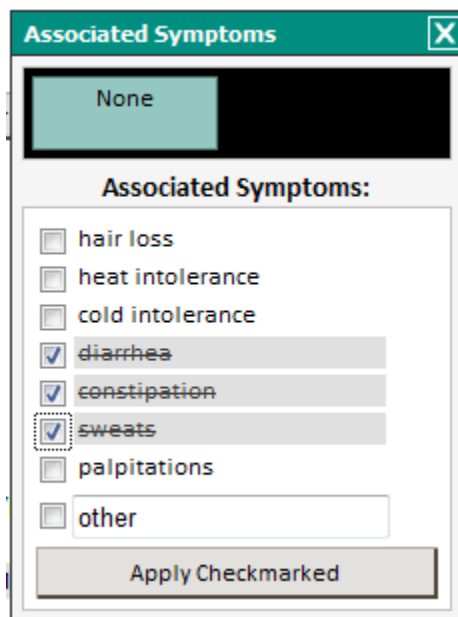


Once a paragraph is selected for insertion, it will change to purple in the template map. The paragraph may be removed by reselecting the title of the paragraph. Paragraphs that were inserted automatically based on entries into other paragraphs cannot be removed in this manner.

Double Clicking Options from Multi-choice Boxes

- Double clicking an item in a Multi Choice Box will remove the item from a document.

He denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.



In this example Orthopnea, PND and DOE were double clicked. This results in the following sentence in the document.

He denies chest pain, shortness of breath, edema, palpitations or syncope.

Removal of Physical Exam Option

Physical Examination

FREE TEXT OPTION DELETE VITALS Vitals: Reviewed per Nurses Notes. SHOW WEIGHT SHOW HEIGHT SHOW WC SHOW O2 SAT SHOW BMI
DELETE HEENT EXAM HEENT: Facies- Within normal limits. Pinnae- Normal texture and shape bilaterally. Canals- Normal bilaterally. TMs- Normal bilaterally. Nasopharynx- Patent bilaterally. Nasal Septum- is normal. There is no tenderness to palpation over the frontal or maxillary sinuses. Lids- Normal bilaterally. Conjunctiva- Clear bilaterally. Sclera- Anicteric bilaterally. Oropharynx- Moist with no lesions. Tonsils- No enlargement, erythema or exudate.


By clicking on HEENT a pop-up box will appear where the desired elements of the HEENT exam may be selected.



Selecting HEENT DEFER will cause the exam to read HEENT: Deferred.

Selecting HEENT INSERT will insert the entire HEENT examination.

Selecting HEENT SELECT will result in a pop-up allowing selection of the elements of the exam for display.

DELETE HEENT EXAM HEENT: SELECT ITEMS TO SHOW 

Then choose **SELECT ITEMS TO SHOW**.

To Show [X]

Select

Select Items to Show:

<input type="checkbox"/> Facies	<input type="checkbox"/> Eyelids
<input type="checkbox"/> Pinna	<input type="checkbox"/> Conjunctiva
<input type="checkbox"/> Canal	<input type="checkbox"/> Sclera
<input type="checkbox"/> TMs	<input type="checkbox"/> Oral Membranes
<input type="checkbox"/> Nares	<input type="checkbox"/> Tonsils
<input type="checkbox"/> Nasal Septum	<input type="checkbox"/> Head
<input type="checkbox"/> Sinuses	

[Apply Checkmarked]

To Show [X]

Select

Select Items to Show:

<input type="checkbox"/> Facies	<input type="checkbox"/> Eyelids
<input checked="" type="checkbox"/> Pinna	<input type="checkbox"/> Conjunctiva
<input checked="" type="checkbox"/> Canal	<input type="checkbox"/> Sclera
<input checked="" type="checkbox"/> TMs	<input type="checkbox"/> Oral Membranes
<input type="checkbox"/> Nares	<input type="checkbox"/> Tonsils
<input type="checkbox"/> Nasal Septum	<input type="checkbox"/> Head
<input type="checkbox"/> Sinuses	

[Apply Checkmarked]

Click on “apply checkmarked” and the exam will now appear as follows:

DELETE HEENT EXAM **HEENT: SHOWING:** Pinna, Canal and TMs Pinnas- Normal texture and shape bilaterally. Canals- Normal bilaterally. TMs- Normal bilaterally.

DELETE NECK EXAM **Neck:** Thyroid- non enlarged, symmetric and has no nodules or bruits. ROM- Normal Range of Motion with no rigidity.

Other examination sections of Clicktate have similar functionality. Please explore each examination section to see the specific features inherent to each section.

Drag and Delete Function

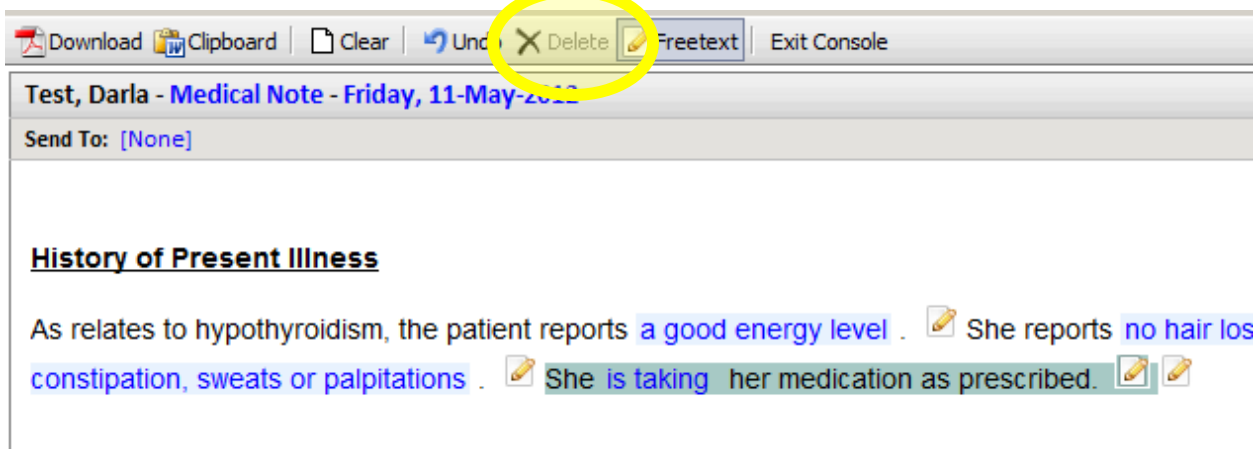
Any text (except for the medication list, allergy list and medication manager sections) may be selected and deleted by using the drag and delete function.

History of Present Illness

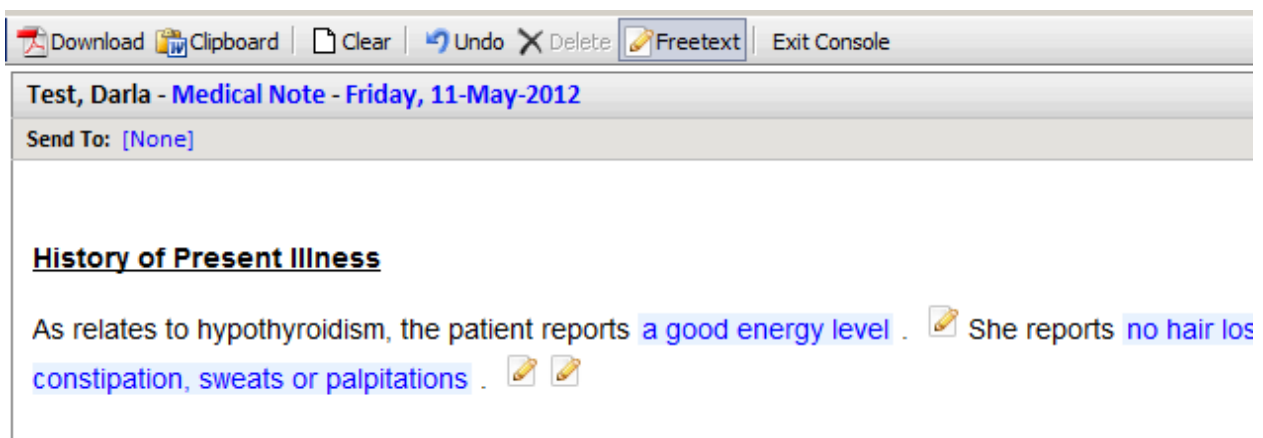
The patient presents for follow-up of hyperlipidemia. She is following a low fat diet. She reports that she is not exercising. She is not taking medication for hyperlipidemia. She denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope.

As relates to hypertension, the patient reports that she has had no headaches or blurred vision. SHOW DIETARY SHOW EXERCISE She states that she is taking her medication as prescribed. D She is not having medication side effects. D She does not check her blood pressures at home.

After the text is selected, clicking the Delete button will delete that section of text.



Resulting in:



REMEMBER: ANY WORDS IN CLICKTATE THAT ARE BLUE OR PURPLE MAY BE CHANGED. EXPLORE THE SYSTEM AND NOTES TO LEARN THE FUNCTIONALITY AND PURPOSE OF EACH SMART PROMPT.

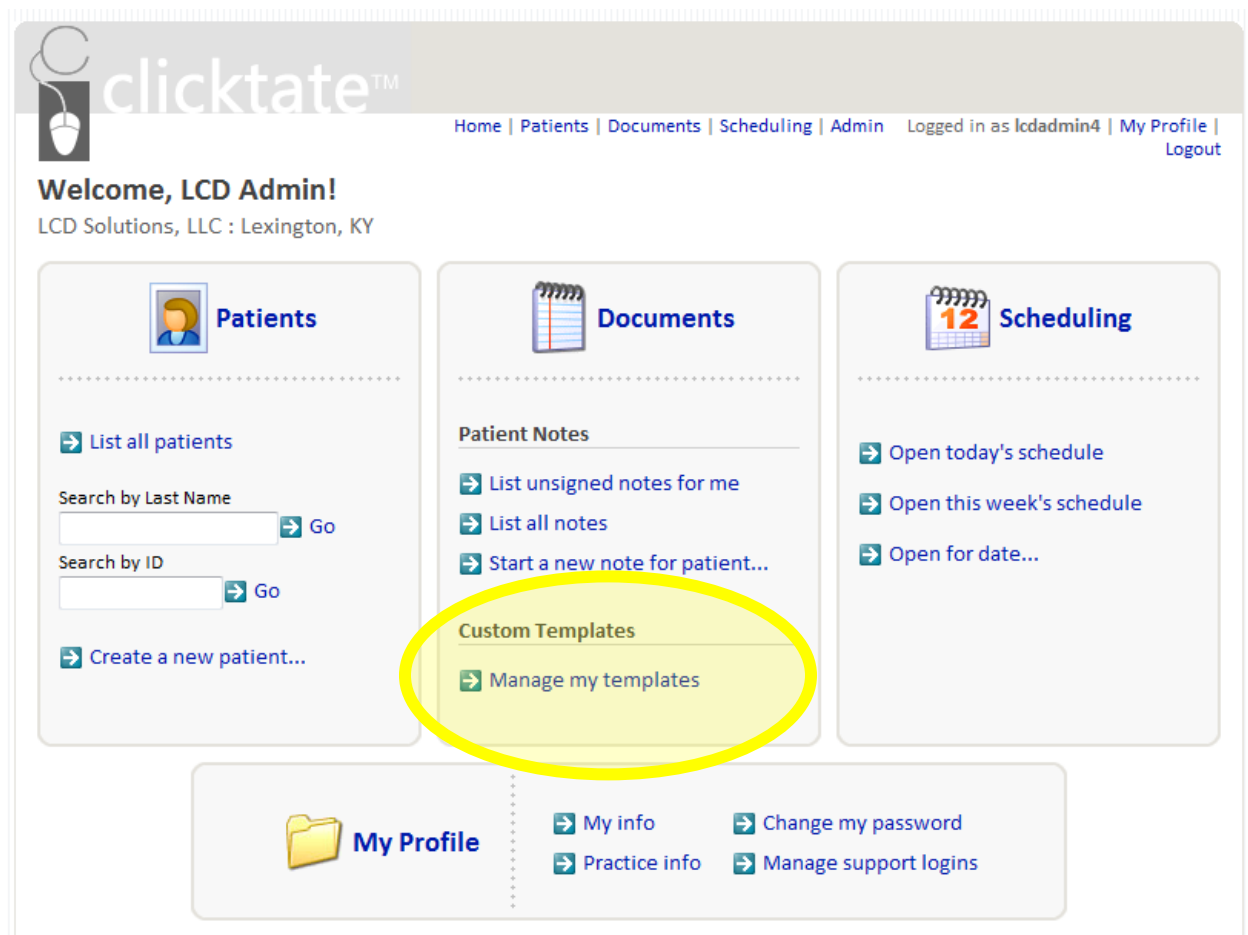
Section VII: Custom Template Design and Creation

One of the advances seen in Clicktate is the ability to work with custom templates. Custom templates are templates that are based on existing Clicktate system templates but they are user defined or modified and saved for use with the same patient or different patients at a later time. The custom templates have a user defined name.

Working with Custom Templates

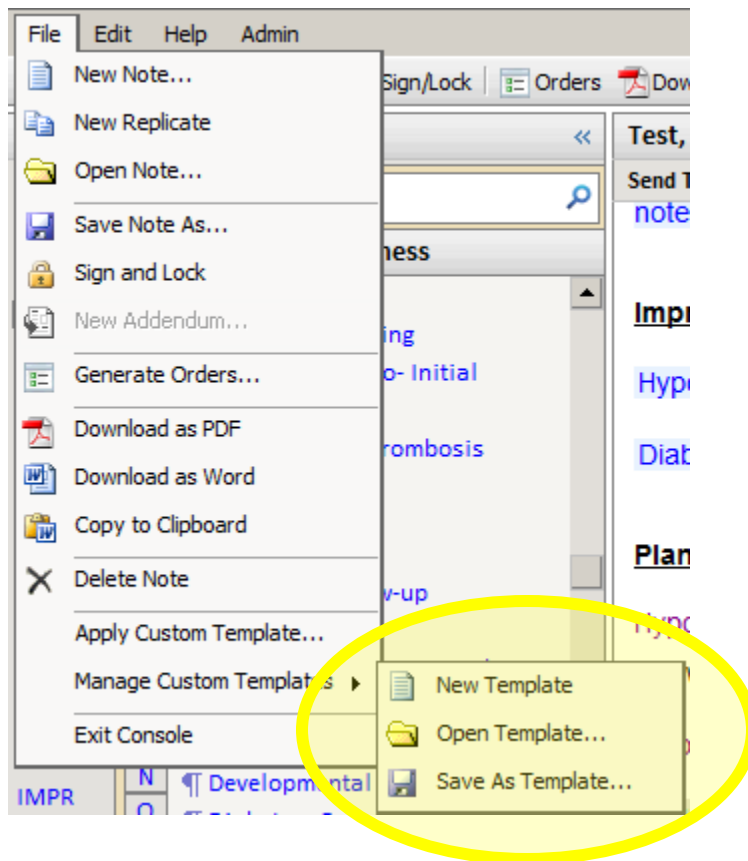
There are **two main entry points** for designing, building and working with custom templates:

- From the Home Page



From the home page, select “Manage my templates”.

- From the Patient Console



From the patient console, select either New Template or Open Template from within the File Menu. A note that has been created for a particular patient may be saved as a template using the “Save As Template...” function. This note could then be used for other patients in the future.

Starting a New Template









To start a new template from scratch, select New Template from the File Menu as noted above or select Start a New Template from the Home page by selecting “Manage my templates” and then “Create New Custom Template”.


Document Manager

Showing: **Customized templates**










[Manage notes](#)

Records 1 to 8

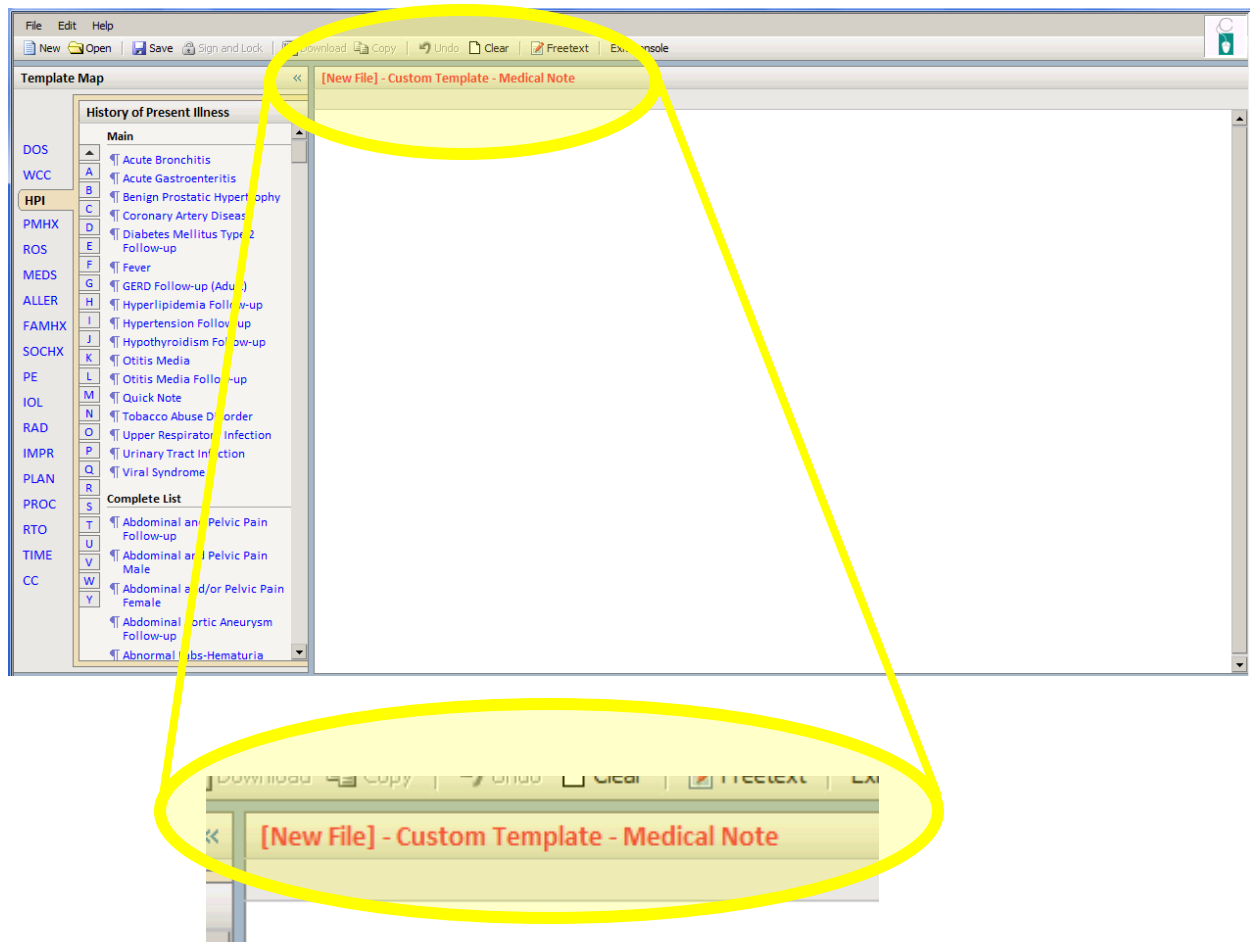
Custom Template	Based On	Created	Last Updated ▼
 John Template	Medical Note	2009-10-16 11:29:42 (MM)	2009-10-16 11:29:42
 HL HTN HOTHY	Medical Note	2009-09-03 23:35:27 (MM)	2009-09-03 23:35:27
 Hyperlipidemia on Lipitor	Medical Note	2009-09-03 23:12:30 (MM)	2009-09-03 23:12:30
 tiffany note hyperlipidemia	Medical Note	2009-07-31 11:52:21 (MM)	2009-07-31 12:07:30 (MM)
 test template hl htn dm 072409	Medical Note	2009-07-24 11:11:25 (MM)	2009-07-24 11:11:25
 a	Medical Note	2009-03-31 14:19:12 (CM)	2009-03-31 14:19:12
 Smoker with Bronchitis	Medical Note	2009-03-30 19:26:10 (CM)	2009-03-30 19:26:10
 Smoking Problem	Medical Note	2009-03-30 19:24:47 (CM)	2009-03-30 19:24:47

 Create New Custom Template

After starting a new template, you will be prompted to select the note type on which the template will be based.

Records 1 to 8			
Custom Template	Based On	Created	Last Updated ▼
 John Template	Medical Note	2009-10-16 11:29:42 (MM)	2009-10-16 11:29:42
 HL HTN HOTHY	Medical Note	2009-09-03 23:35:27 (MM)	2009-09-03 23:35:27
 Hyperlipidemia on Lipitor	<div><div>New Custom Template</div><div>Based On Medical Note</div><div> Start Custom Template > Cancel</div></div>	2009-09-03 23:12:30 (MM)	2009-09-03 23:12:30
 tiffany note hyperlipidemia		2009-07-31 12:07:30 (MM)	2009-07-31 12:07:30 (MM)
 test template hl htn dm 072409		2009-07-24 11:11:25 (MM)	2009-07-24 11:11:25
 a		2009-03-31 14:19:12 (CM)	2009-03-31 14:19:12
 Smoker with Bronchitis	Medical Note	2009-03-30 19:26:10 (CM)	2009-03-30 19:26:10
 Smoking Problem	Medical Note	2009-03-30 19:24:47 (CM)	2009-03-30 19:24:47

You will then be directed to the patient console, where a blank document with the selected Template Map will be presented. This note is NOT patient connected; this is denoted by the banner at the top of the console which doesn't have a patient name. It instead, will state “[New File]- Custom Template- Medical Note”.



From this screen, create a note as you normally would. Here a note is created for Diabetes and Hypertension.

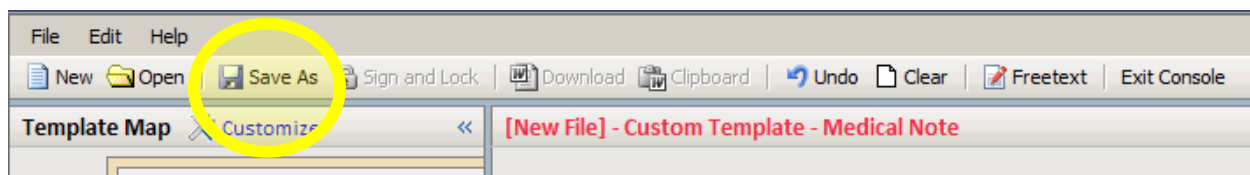
History of Present Illness

The patient reports that she **checks** her blood sugars at home. Her sugars are checked **daily**. The average sugars are in the **100-150** range. **D** She **denies** hypoglycemic symptoms. **D** The patient **denies polyuria, polydipsia or polyphagia**. **D** The last eye exam was within the past year. She usually sees an **ophthalmologist** for her eye examinations. The eye examinations **have been normal**. **D** She reports **no symptoms of neuropathy**. The patient **takes her medication as prescribed**. She **is not** taking insulin. The patient **does** check her feet daily at home. **D** She **denies chest pain, shortness of breath, orthopnea, paroxysmal nocturnal dyspnea, dyspnea on exertion, edema, palpitations or syncope**.

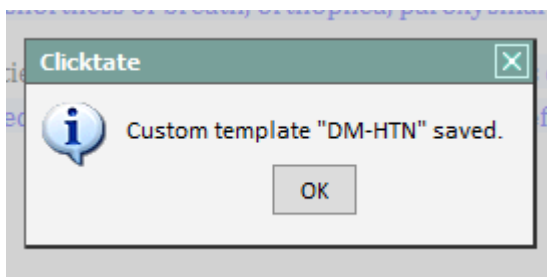
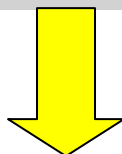
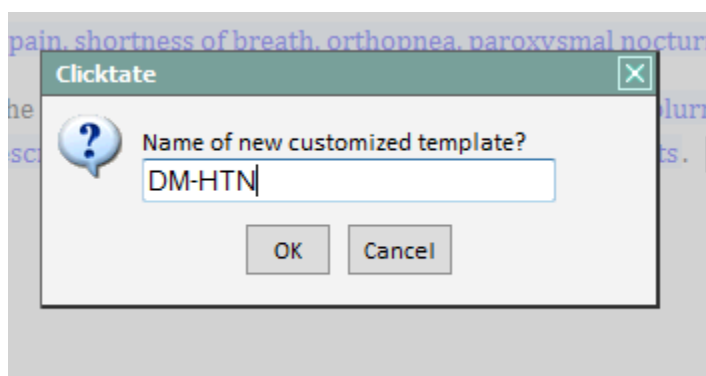
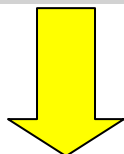
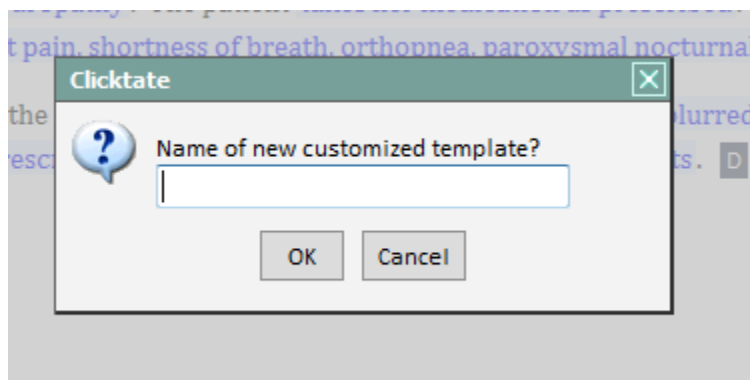
As relates to hypertension, the patient reports that she **has had no headaches or blurred vision**. **SHOW DIETARY** She states that she **is taking her medication as prescribed**. She **is not** having medication side effects including rash, headache, vivid dreams, fatigue, dyspnea, wheezing, sexual dysfunction, edema, cough or abdominal pain. **D** She **does not check** her blood pressures at home.

Medications

Any needed changes may be made and the Save As Button is selected to save the template.



A template pop-up will prompt the template to be named.



The template name “DM-HTN” is now available for use with other patients and in other documents. It can be accessed for any New Note under the Custom Templates dropdown tab.

The screenshot shows a 'Create New Document' window. At the top, the patient name 'Jones, Frank' is displayed next to a 'Choose another' button. Below this, the 'Date of Service' is set to '28-Oct-2009' with a calendar icon. The 'Send To' field shows 'Michael McKinney, M.D.' with a 'Set as default' link. The 'Template' dropdown is set to 'Medical Note' with another 'Set as default' link. A section titled 'Apply Custom Template:' is highlighted with a yellow oval; it contains a dropdown menu with 'DM-HTN (Medical Note)' selected. Below this section is a 'Cancel' button.

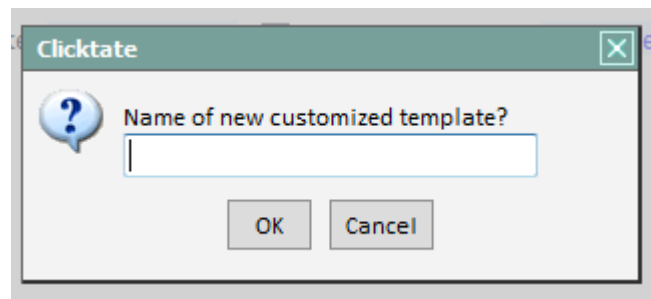
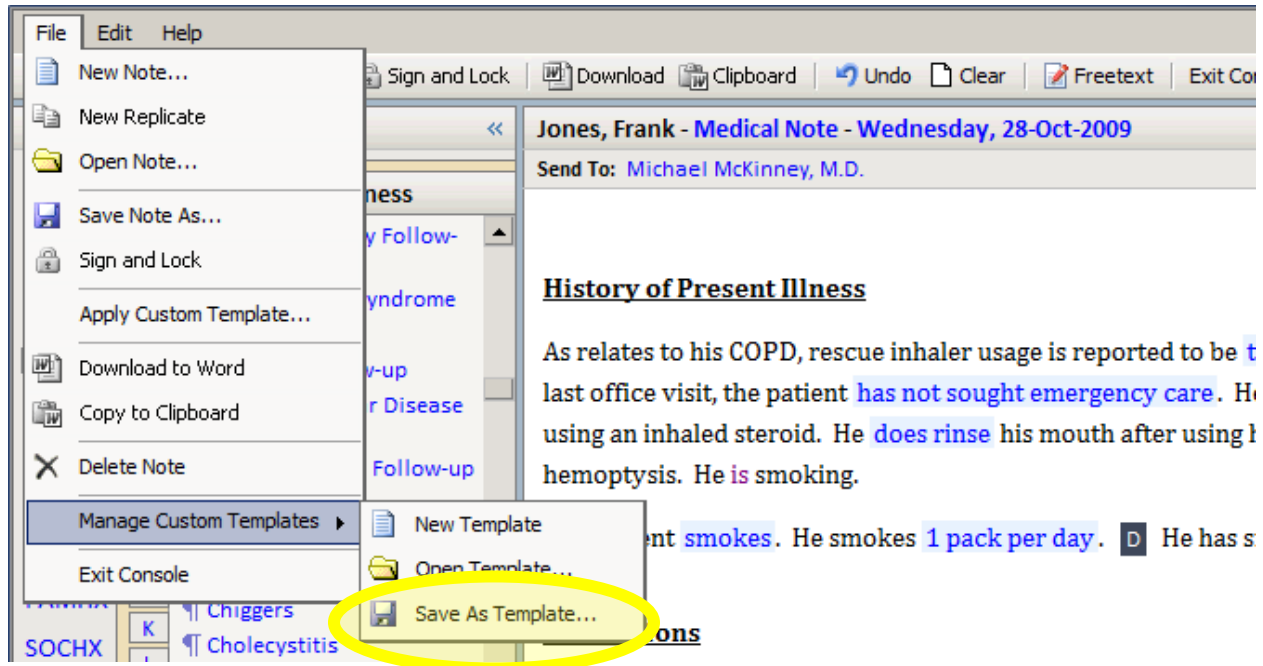
Selecting DM-HTN and then “Apply Custom Template:” will start a new patient note with this template. From the file menu on the note console, templates may also be applied to an active note by selecting “Apply Custom Template...”.

Creating a New Template from a Patient Note

Once a PATIENT note has been created, it can also be saved as a custom template. The first step in this process is to create a patient note.

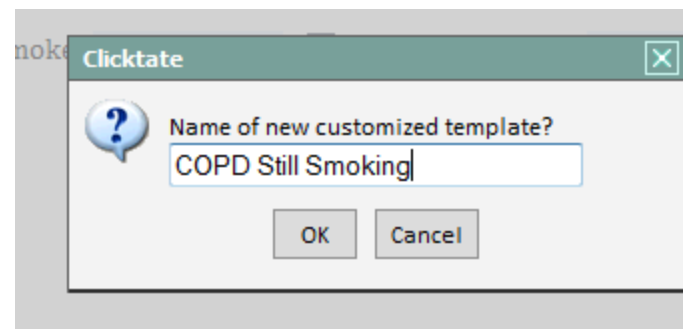
The screenshot shows a patient note for 'Cuppy, Ronald' dated 'Friday, 06-Mar-2009'. The note was created on '06-Mar-2009, 11:18PM by LCD Admin'. The main section is titled 'History of Present Illness'. The text describes the patient's COPD, rescue inhaler usage (two to three times weekly), and reports that he has no known triggers. It also mentions that he has not sought emergency care, currently reports no wheezing, cough, sputum production or dyspnea, is using an inhaled steroid, does rinse his mouth after using his steroid inhaler, doesn't report thrush symptoms or a sore mouth, denies hemoptysis, and is smoking. The note concludes with 'The patient smokes. He smokes 1 pack per day. D He has smoked for 15-20 years.' and includes an 'INSERT PRIOR ATTEMPTS' button.

In this example a note has been created for a COPD patient who continues to smoke. To save this note as a custom template, under the FILE menu, select Custom Templates and then Save As Template.

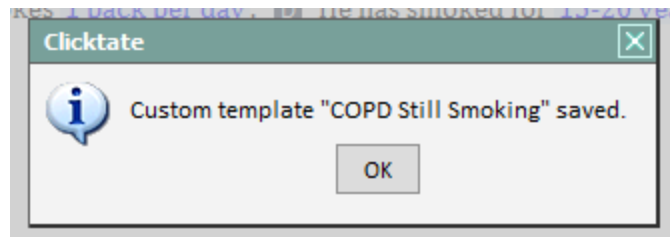


Next assign a name:

Then Click OK

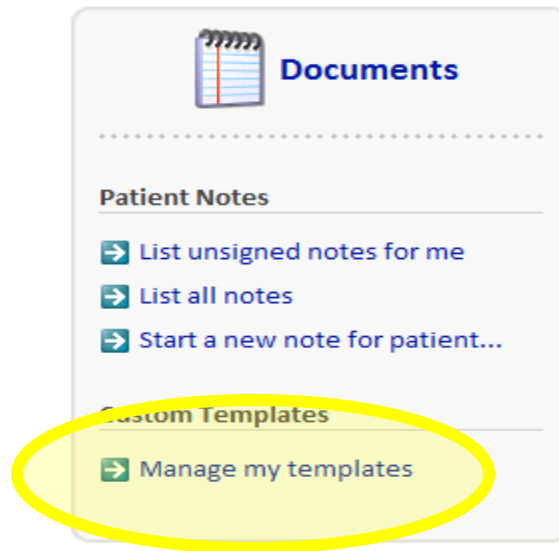


And the template will be available under the custom templates list.



Working with Existing User Defined Templates

Existing templates may be selected for modification from the Home page or from the Patient Console. To select a template from the home page, choose the Manage My Templates option from the Document menu.



This will bring up a list of available user defined templates. Choose the template which you would like to modify.

Document Manager

Showing: **Customized templates**

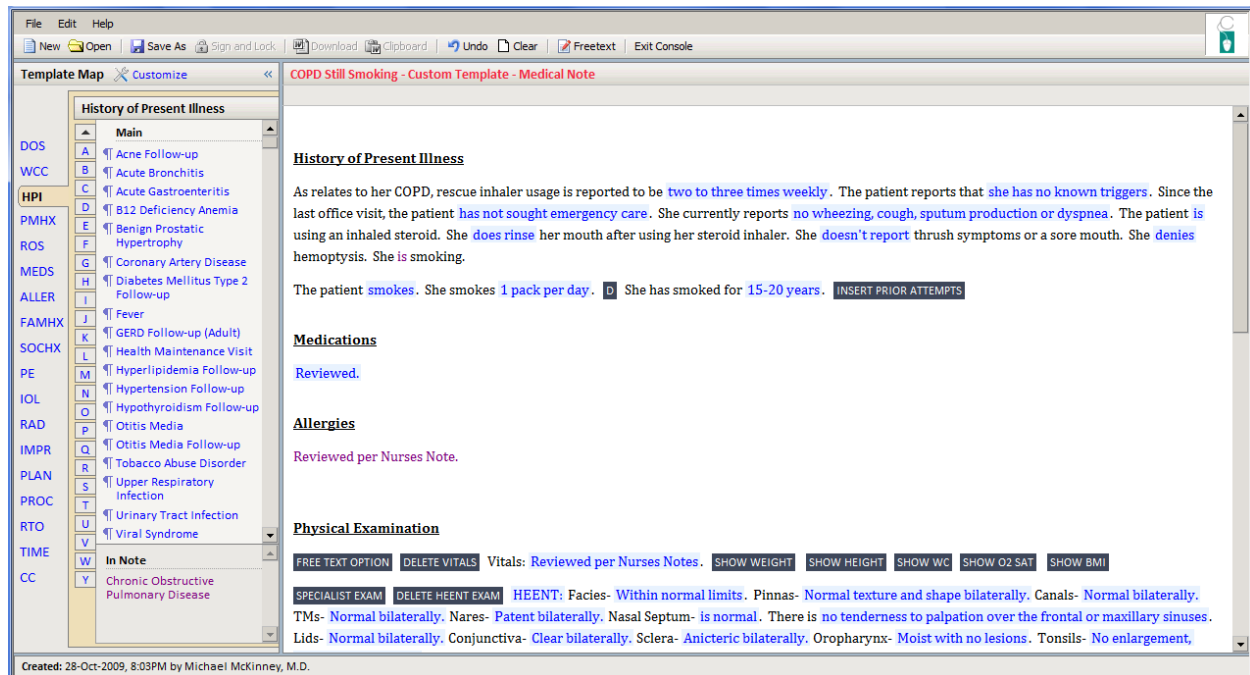
[Manage notes](#)

Records 1 to 10			
Custom Template	Based On	Created	Last Updated ▾
COPD Still Smoking	Medical Note	2009-10-28 20:03:56 (MM)	2009-10-28 20:03:56
DM-HTN	Medical Note	2009-10-28 19:59:01 (MM)	2009-10-28 19:59:01
John Template	Medical Note	2009-10-16 11:29:42 (MM)	2009-10-16 11:29:42
HL HTN HOTHY	Medical Note	2009-09-03 23:35:27 (MM)	2009-09-03 23:35:27
Hyperlipidemia on Lipitor	Medical Note	2009-09-03 23:12:30 (MM)	2009-09-03 23:12:30
tiffany note hyperlipidemia	Medical Note	2009-07-31 11:52:21 (MM)	2009-07-31 12:07:30 (MM)
test template hl htn dm 072409	Medical Note	2009-07-24 11:11:25 (MM)	2009-07-24 11:11:25
a	Medical Note	2009-03-31 14:19:12 (CM)	2009-03-31 14:19:12
Smoker with Bronchitis	Medical Note	2009-03-30 19:26:10 (CM)	2009-03-30 19:26:10
Smoking Problem	Medical Note	2009-03-30 19:24:47 (CM)	2009-03-30 19:24:47

Create New Custom Template

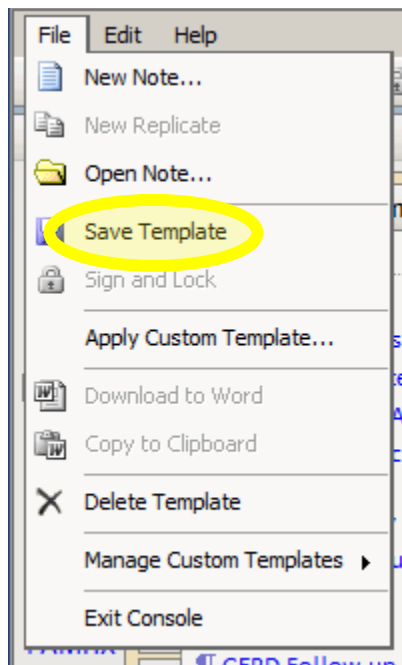
To revise the template “COPD Still Smoking” that was just created, select it from the list of available templates.

When the note opens in the console, it will not be “attached” to a particular patient, and no patient name will appear on the console.

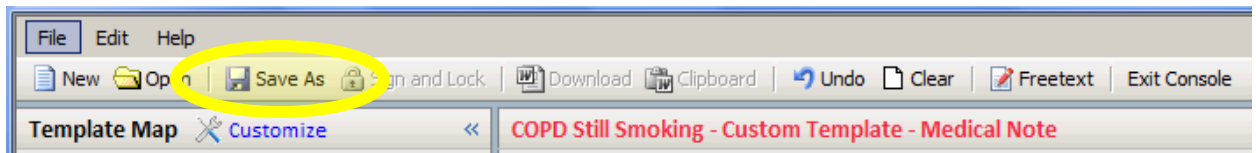


Any desired changes can be made and the template can be:

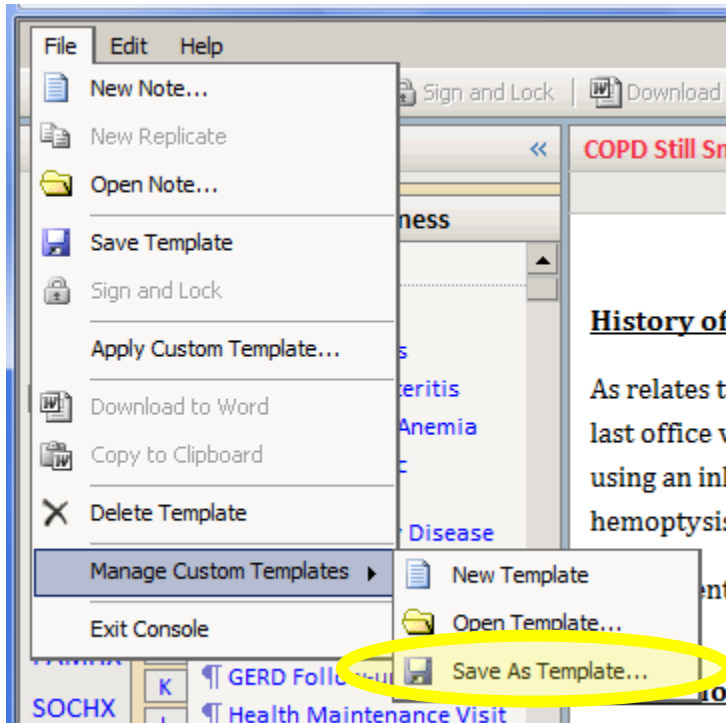
- Saved under the same name by selecting Save Template from the File menu.



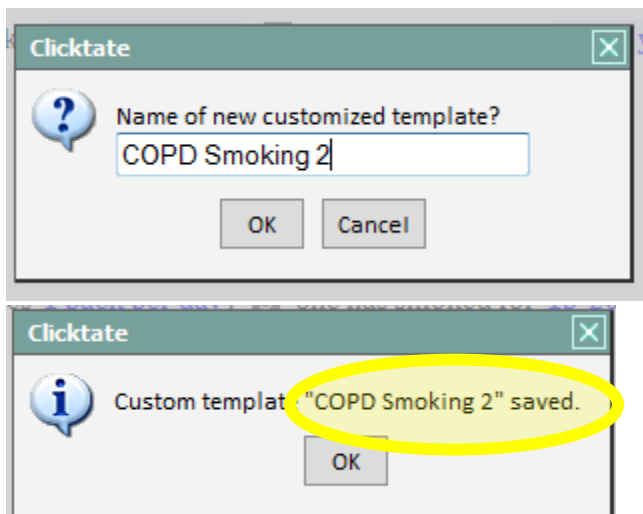
- Saved under a different name by selecting “Save As” from the menu bar



or by selecting Save As Template from the File menu.



By selecting “Save As Template...” the template will be saved under the new name and will be retained under the previous name as well.







Document Manager

Showing: **Customized templates**

[Manage notes](#)

Records 1 to 11

Customized templates	Based On	Created	Last Updated ▾
 COPD Smoking 2	Medical Note	2009-10-28 20:14:49 (MM)	2009-10-28 20:14:49
 COPD Still Smoking	Medical Note	2009-10-28 20:03:56 (MM)	2009-10-28 20:03:56
 COPD Still Smoking	Medical Note	2009-10-28 19:59:01 (MM)	2009-10-28 19:59:01
 John Template	Medical Note	2009-10-16 11:29:42 (MM)	2009-10-16 11:29:42

Patient Specific Templates

After creating a note on the patient console, it may be saved as a patient's Template note. This is the note that will be preferentially replicated from the note generation initial menu.

First create a note for a patient as normal on the patient console.

Here a note has been created based on the Clicktate Hyperlipidemia template. This note has changes that are specific to the patient.

Thomas, Tony - Medical Note - Wednesday, 28-Oct-2009

Send To: [Michael McKinney, M.D.](#)

History of Present Illness

The patient presents for follow-up of hyperlipidemia. He **is** following a low fat diet. He **reports that he is** exercising. He is taking **Lipitor and over the counter omega 3 fish oils**. The patient **is** taking his medication as prescribed. He reports **no medication side effects, including muscle cramps, abdominal pain, headaches or weakness**. He **denies chest pain, shortness of breath, edema, palpitations or syncope**.

Medications

Reviewed.

Allergies

Reviewed per Nurses Note.

To save the note as the template for this patient, select Save As from the menu bar.

File Edit Help

New Open Save As Sign and Lock Download Clipboard Undo Clear Freetext Exit Console

Template Map Customize <<

Thomas, Tony - Medical Note - Wednesday, 28-Oct-2009

Send To: [Michael McKinney, M.D.](#)

Save Note As

Thomas, Tony

Label:

Date of Service:

☐ Use as patient's standard Medical Note

Save Note

Next, give the template a name and check the “Use as patient’s standard Medical Note” box.

Save Note As

Thomas, Tony

Label:

Date of Service:

☒ Use as patient's standard Medical Note

Save Note

Select “Save Note” and the note will become the standard note for the patient. Upon opening a new note for the patient in the future, this note will appear in the menu box as an option to use as a template for the new note.

Create New Document

Thomas, Tony Choose another

Date of Service:

Send To: Set as default

Template: Set as default

Blank Medical Note

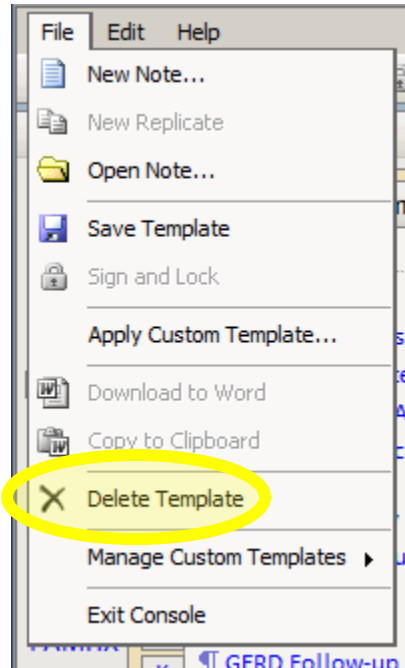
Replicate from Patient History
Hyperlipidemia Follow-up DOS: 28-Oct-2009

Apply Custom Template:

Deleting User Created Templates

To delete a template:

- Open the template as already outlined.
- From the File menu, select Delete Template.



This will **permanently** delete the template.

Free Text in User Created Templates

When free text is inserted into a document that is saved as a template, it will appear in documents which are based on the template. It is important to note that the free text will appear EXACTLY as it was typed, **including gender specific terms**. While other gender specific terms in user created templates will change to reflect the correct gender of the patient, **free text gender terms will not change**. The same applies to the age of the patient. **For this reason, it is best to avoid gender specific terms and ages in free text boxes that are part of documents that you intend to save as templates.**

Document Synchronization with User Created Templates

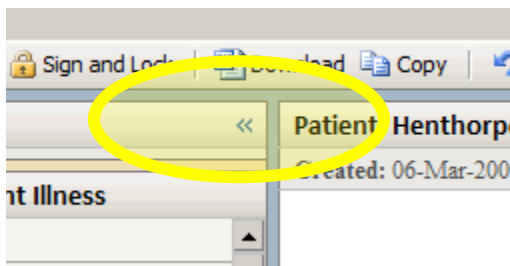
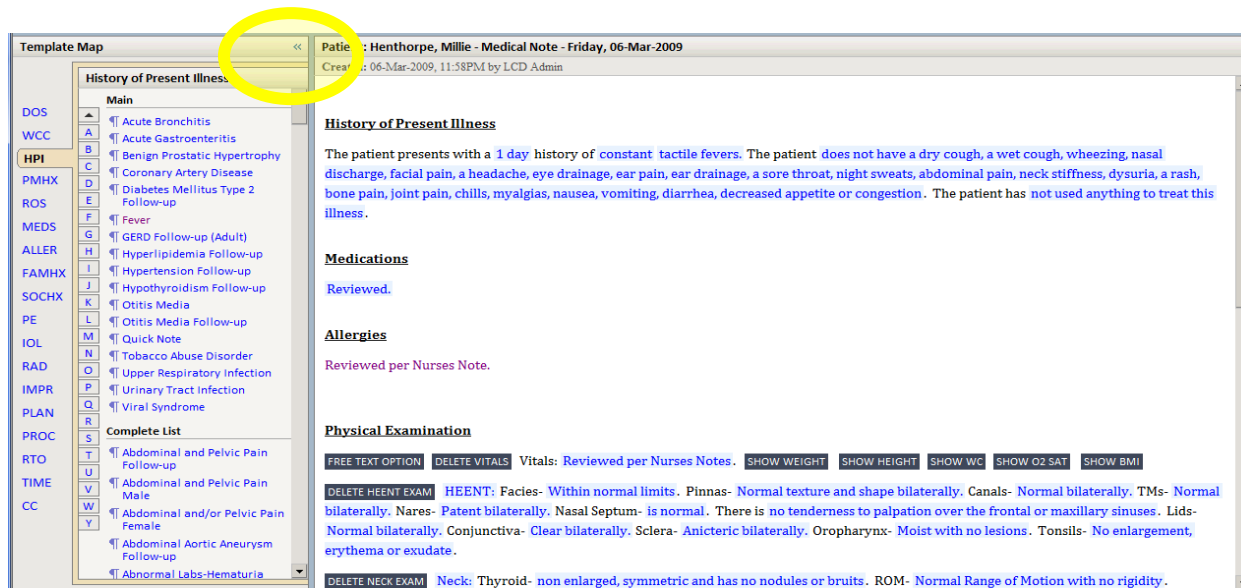
User created templates will stay “in sync” with the remainder of the document, just as other templates do. This means that if you select a chest pain option from a check box, the system will remember the response and other paragraphs that may be inserted will stay synchronized with this paragraph.

The exception to this rule involves Free Text. **The system will not synchronize Free Text throughout the document.** Therefore, it is important to carefully read each document to assure that all options are appropriately checked.

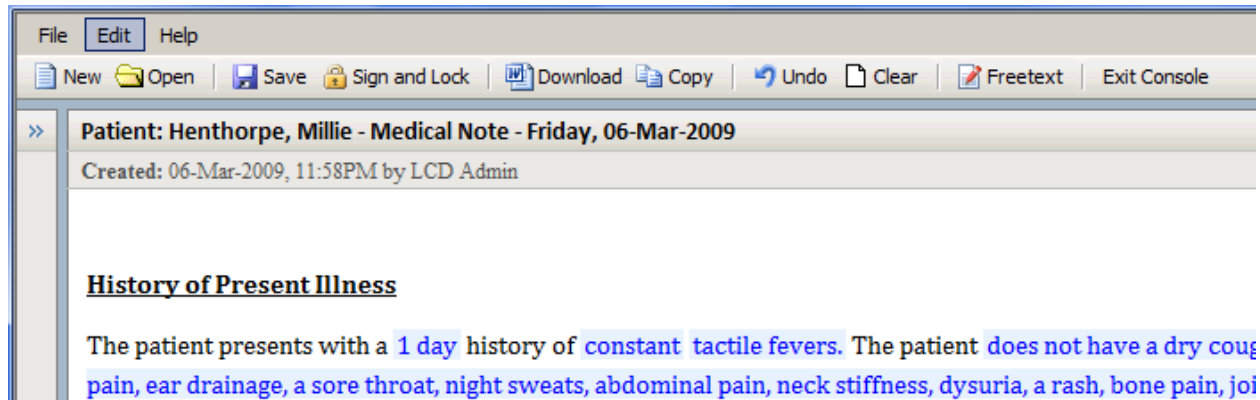
Section VIII: Other Features

Page Layout Expansion

The available document reading area may be expanded by closing the Template Map. To close the template map, click the Page Layout Expansion button.



After the Template Map is closed the readable area of the screen will increase.

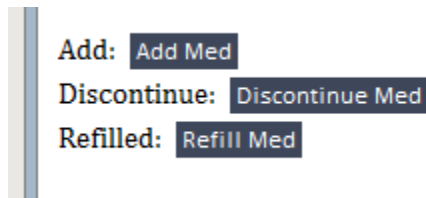


Clicking the Page Layout Expansion button a second time will cause the Template Map to reappear.

The Med Pop-up and Writing Prescriptions

NOTE: THIS SECTION DISCUSSES PRESCRIPTIONS WRITTEN USING THE LEGACY (NON-ONC CERTIFIED) VERSION OF CLICKTATE. MOST CURRENT USERS WILL USE ELECTRONIC PRESCRIBING TO WRITE PRESCRIPTIONS AND MANAGE MEDICATIONS. THIS IS DISCUSSED ELSEWHERE IN THIS MANUAL

To select medications, a medication Pop-up Icon is present in most templates.



The Med Pop-up Icon will state ADD MED, DISCONTINUE MED, or REFILL MED. By selecting this icon, the Med Pop-up box will appear.

A dialog box titled 'Clicktate - Med Selector'. It contains a 'Name / Strength' search box with a 'Search...' button. Below are fields for 'Amount', 'Freq', 'Route', 'Length', and 'Disp'. There are checkboxes for 'As needed' and 'With meals'. A large 'Name Search Results' area is currently empty. At the bottom are 'OK' and 'Cancel' buttons.

To Search for a medication, type a medication name or partial medication name in the Name Box. Let's search for Augmentin.

Clicktate - Med Selector

Name / Strength
augm

Search...

Amount Freq

☐ As needed ☐ With meals

Route Length Disp

Name Search Results

Type in a partial name and hit ENTER for results.

OK Cancel

Click the SEARCH button.

Clicktate - Med Selector

Name / Strength
augm

Search...

Amount Freq

☐ As needed ☐ With meals

Route Length Disp

Available options for the medication will appear.

Clicktate - Med Selector

Name / Strength
augm Search...

Amount Freq
 ☐ As needed ☐ With meals

Route Length Disp

Name Search Results

Searching for: AUGM

AUGMENTIN '125' (125MG/5ML; EQ 31.25MG BASE/5ML)
AUGMENTIN '125' (125MG; EQ 31.25MG BASE)
AUGMENTIN '200' (200MG/5ML; EQ 28.5MG BASE/5ML)
AUGMENTIN '200' (200MG; EQ 28.5MG BASE)
AUGMENTIN '250' (250MG/5ML; EQ 62.5MG BASE/5ML)
AUGMENTIN '250' (250MG; EQ 62.5MG BASE)
AUGMENTIN '250' (250MG; EQ 125MG BASE)
AUGMENTIN '400' (400MG/5ML; EQ 57MG BASE/5ML)
AUGMENTIN '400' (400MG; EQ 57MG BASE)
AUGMENTIN '500' (500MG; EQ 125MG BASE)
AUGMENTIN '875' (875MG; EQ 125MG BASE)

OK Cancel

Next select the desired formulation of Augmentin from the list. Here, we'll select Augmentin 875mg.

Clicktate - Med Selector

Name / Strength
 AUGMENTIN '875' (875MG; EQ 125MG BASE)

Amount **Freq** ☐ As needed ☐ With meals

Route **Length** **Disp**

Amount Options

1/4	1/3	1/2	1/2 - 1	1	2	3
4	5					
1/4 tsp	1/3 tsp	1/2 tsp	3/4 tsp	1 tsp	1 1/4 tsp	1 1/3 tsp
1 1/2 tsp	1 3/4 tsp	2 tsp	3 tsp			
0.4 ml	0.8 ml	1 ml	1.2 ml	1 1/2 ml	1.6 ml	2 ml
2 1/2 ml	3 ml	3 1/2 ml	4 ml	4 1/2 ml	5 ml	
1 drop	2 drops	3 drops	4 drops	5 drops	10 drops	
1 puff	2 puffs	4 puffs	8 puffs	16 puffs		
1/2 capful	1 capful	17 gms				
as directed						

You may now select the AMOUNT, FREQUENCY, ROUTE, and LENGTH.

Adding of Length to a medication will result in the medication expiring and being moved to the inactive medication list.

Long term medications should NOT have a length specified.

If the desired selection isn't present in the selection box, just type in what you would like to have appear in your document. You can do this in any field of the Med Pop-up. For instance, if you prescribe a special formula for an infant, this could be placed into the Med Pop-up.

Clicktate - Med Selector

Name / Strength

Amount **Freq**

☐ As needed ☐ With meals

Route **Length** **Disp**

Amount Options

1/4	1/3	1/2	1/2 - 1	1	2	3
4	5					
1/4 tsp	1/3 tsp	1/2 tsp	3/4 tsp	1 tsp	1 1/4 tsp	1 1/3 tsp
1 1/2 tsp	1 3/4 tsp	2 tsp	3 tsp			
0.4 ml	0.8 ml	1 ml	1.2 ml	1 1/2 ml	1.6 ml	2 ml
2 1/2 ml	3 ml	3 1/2 ml	4 ml	4 1/2 ml	5 ml	
1 drop	2 drops	3 drops	4 drops	5 drops	10 drops	
1 puff	2 puffs	4 puffs	8 puffs	16 puffs		
1/2 capful	1 capful	17 gms				
as directed						

Here Similac with Iron was typed in manually, as was the amount.

Another feature of the Med Pop-up is that if you don't type anything in to the Add Med/ Discontinue Med/ Refill Med selector in the PLAN section of most templates, this section will not appear in the final document.

Add:

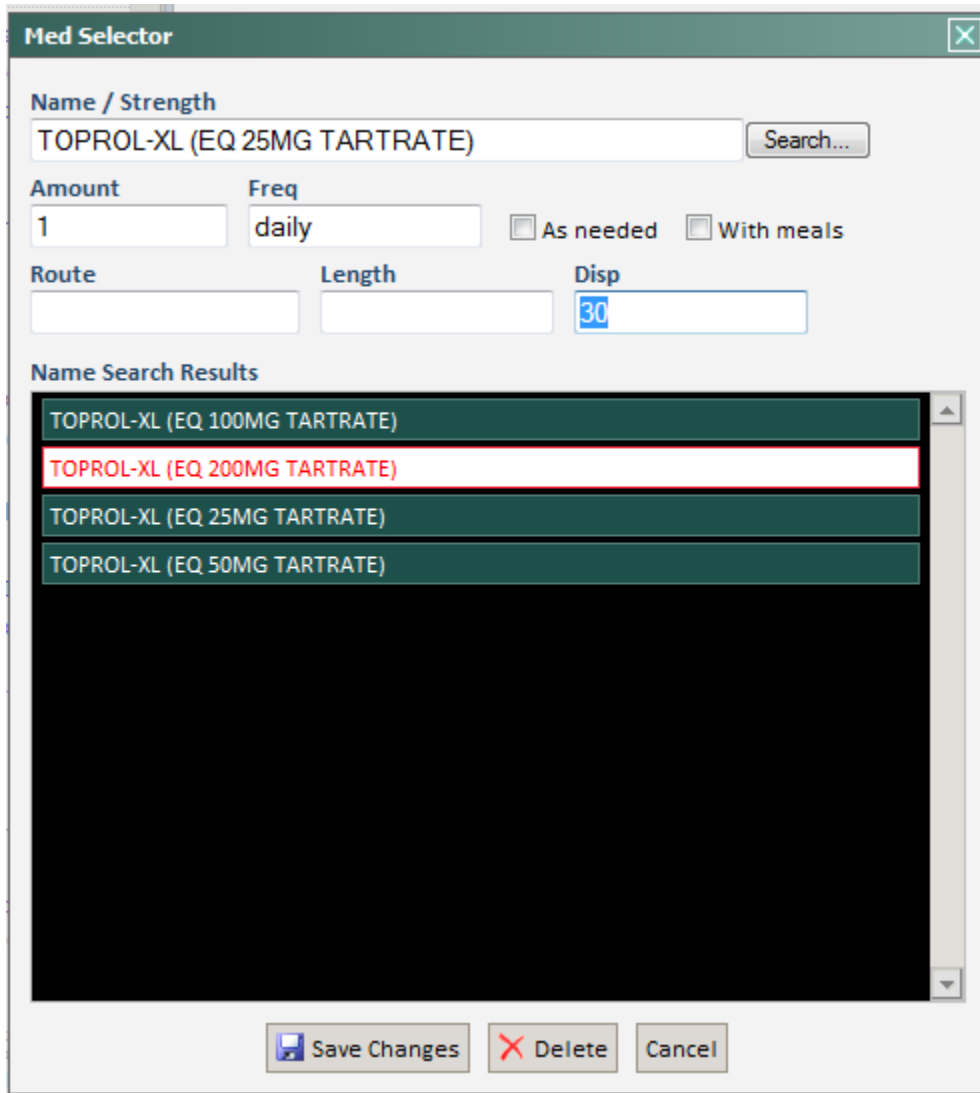
Discontinue:

Refilled:

If nothing is added here, this section will not appear in the final document

Printing Prescriptions

Once a medication has been entered, a prescription may be printed. (*e-prescribing is a future feature which is currently in development.*)



The 'Med Selector' dialog box is shown. It has a title bar with a close button. The main area contains several input fields: 'Name / Strength' with a text box containing 'TOPROL-XL (EQ 25MG TARTRATE)' and a 'Search...' button; 'Amount' with a text box containing '1'; 'Freq' with a text box containing 'daily' and two checkboxes, 'As needed' and 'With meals'; 'Route' with an empty text box; 'Length' with an empty text box; and 'Disp' with a text box containing '30'. Below these fields is a section titled 'Name Search Results' with a list box containing four items: 'TOPROL-XL (EQ 100MG TARTRATE)', 'TOPROL-XL (EQ 200MG TARTRATE)' (highlighted with a red border), 'TOPROL-XL (EQ 25MG TARTRATE)', and 'TOPROL-XL (EQ 50MG TARTRATE)'. At the bottom are three buttons: 'Save Changes', 'Delete', and 'Cancel'.

By entering a medication Amount, Frequency and Length, Clicktate will calculate the Dispense amount for the prescription. After the medication is entered into the document, a PRINT RX button will appear.

Add:

- TOPROL-XL (EQ 25MG TARTRATE) 1 daily (Disp: 30) **Print RX**

Add Med


Discontinue: Discontinue Med

Refilled: Refill Med

Select to "Print RX" button to generate a prescription.

A prescription pop-up will appear.

Clicktate - Print Medications



Mark Winters, MD
Complete Care Medical Group
100 Caring Way Suite 200 Sunnyville, KY 40356
888-825-4258
Lic: 00000 (KY) DEA: BM00000000 NPI: 0000000000

		Disp	Refills	DNS	DAW	
<input checked="" type="checkbox"/>	Medication	Sig	30-day ▾	None ▾	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	TOPROL-XL (EQ 25MG TARTRATE)	Take 1 daily	30	None ▾	<input type="checkbox"/>	<input type="checkbox"/>

Print checked as: ☒ RX (4 per page) ☐ RX (1 per page)

Exit


Final edits to the prescription, such as number of refills and substitution status may be selected. Selecting OK will generate a prescription for printing. In addition, prescriptions may be printed as one page or four per page.

Mark Winters, MD
Complete Care Medical Group
100 Caring Way Suite 200 Sunnyville, KY 40356
888-825-4258
Lic: 00000 (KY) DEA: BM00000000 NPI: 0000000000

Date: 1/30/2010

Name: Cuppy, Bobbi

DOB: 03/10/1970



TOPROL-XL (EQ 25MG TARTRATE)
Sig: Take 1 daily
Disp: 30
Refills: 0

Signature _____

The prescription may then be printed. Once this page is displayed, the prescription information will appear in the note, EVEN IF THE PRESCRIPTION IS NOT PRINTED.

Add:

- TOPROL-XL (EQ 25MG TARTRATE) 1 daily (Disp: 30) (RX 1/30/2010 Disp: 30, Refills: 0)

Discontinue:

Refilled:

To add additional medications, again select the Add Med button.

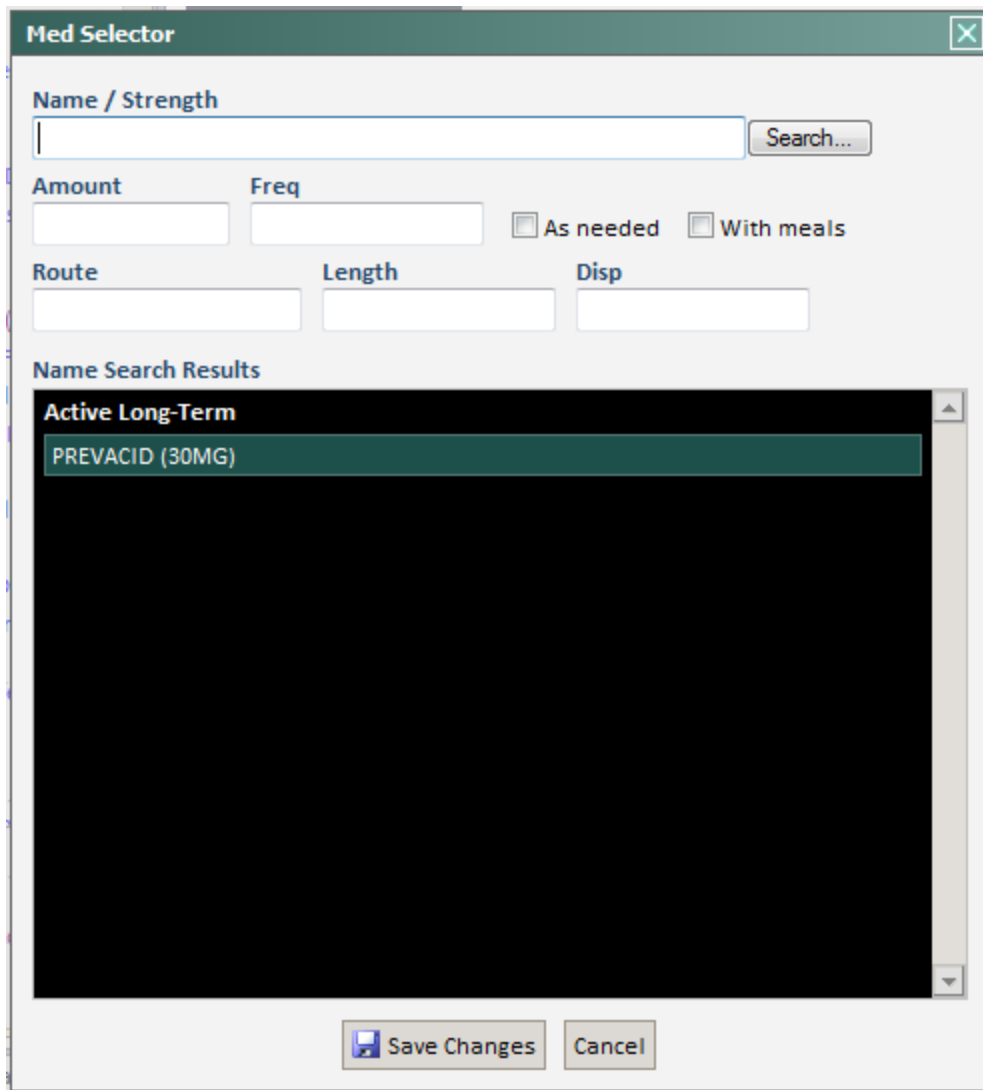
To discontinue a medication, select the Discontinue Med button.

Add:

- TOPROL-XL (EQ 25MG TARTRATE) 1 daily (Disp: 30) (RX 1/30/2010 Disp: 30, Refills: 0)

Discontinue:

Refilled:



The image shows a 'Med Selector' dialog box with a title bar and a close button. It contains several input fields and checkboxes for medication selection. The 'Name / Strength' field is empty, and the 'Search...' button is to its right. Below this are 'Amount' and 'Freq' fields, followed by checkboxes for 'As needed' and 'With meals'. There are also 'Route', 'Length', and 'Disp' fields. A 'Name Search Results' section contains a list with the header 'Active Long-Term' and one item, 'PREVACID (30MG)', which is highlighted. At the bottom are 'Save Changes' and 'Cancel' buttons.

Med Selector

Name / Strength Search...


Amount Freq ☐ As needed ☐ With meals

Route Length Disp

Name Search Results

Active Long-Term

- PREVACID (30MG)

 Save Changes Cancel

Then select the desired medication from the list in the medication pop-up. The medication will be listed on discontinued and the Facesheet medication list will be updated after the note is signed and locked.

Section IX: The Facesheet

The Facesheet allows:

- The ability to input, retain and work with medication lists
- The ability to input, retain and work with allergy lists
- The input, retention, tracking and graphing of vital signs
- Patient demographic recording
- Health Maintenance and recurring tests tracking, maintenance and reminders
- Quick Viewing of Prior Patient Data
- Quick input and review of past medical history, past surgical history, family medical history and psychosocial history
- Immunization records
- Growth charts
- Workflow tracking
- Review and reconciliation of patient history, medications and allergies chronologically and as they relate to medical notes

Each section of the Facesheet has an expand toggle. This toggle, when activated, expands the section allowing the user to input and update data. Data from the allergy, vital signs, and medication sections and certain data from the Health Maintenance section will automatically populate notes. Also, data from **signed** notes will automatically update the Facesheet.

After selecting a patient from either the patient menu or the calendar, the patient Facesheet will appear.

Home | Patients | Documents | Sched | Track | Scan | Lab | Report | NQF Rx Pharm Rx Status 1 Review Msg

Logan, Arnold Download/Print Search for patient

Upload
 ID: 345634 DOB: 05-Jan-1946 Age/Sex: 66 male
 Address: 654 Broadhead Place • Lexington, KY 40515
 Phone(s): 888-825-4258 (Primary)

Open

Add Notes

Quick Links
 New Appointment... Record Today's Vitals...
 Medical Note (28-May-2012) Medical Note (27-Apr-2012) Medical Note (07-Feb-2012)
 Create New Document... New Message...

Active Allergies

PENICILLINS Severe: Anaphylaxis

SULFA (SULFONAMIDES) Moderate: Rash

Diagnoses
 CORONARY ARTERY DISEASE (414.01)
 HYPERTENSION (997.91)
[Lookup ICD...](#)

Medications
 DYAZIDE 37.5 MG-25 MG CAP 1 capsule DAILY by mouth
 LIPITOR 10 MG TAB 1 tablet QHS by mouth
[Prescribe...](#)

Medical / Surgical History

Family History

Psycho-Social History
 Tobacco

Immunizations
 Pneumococcal

Order Entry & Tracking
 CRP • TSH

Clinical Decision Support

Item	Frequency	Last Recorded
<input checked="" type="checkbox"/> BMP WITH DIURETIC USAGE	Every 1 year(s)	(None)
<input checked="" type="checkbox"/> COLONOSCOPY	Every 10 year(s)	(None)
<input checked="" type="checkbox"/> PROSTATE EXAMINATION	Every 1 year(s)	(None)
<input checked="" type="checkbox"/> PSA	Every 1 year(s)	(None)
<input checked="" type="checkbox"/> TETANUS BOOSTER	Every 10 year(s)	(None)
<input checked="" type="checkbox"/> AAA SCREENING	N/A	(None)
<input checked="" type="checkbox"/> ASPIRIN USAGE RECOMMENDED	N/A	(None)

Clinical Data and Documentation

Date	Type	Link
08-Jun-2012	Proc/Result	Lipid Profile
04-Jun-2012	Document	Medical Note (Signed)
01-Jun-2012	Document	Medical Note (Signed)
	Proc/Result	Urinalysis
31-May-2012	Document	Medical Note (Signed)
	Proc/Result	HgA1c
	Proc/Result	Hematocrit
28-May-2012	Document	Medical Note
27-Apr-2012	Order	TSH
	Order	CRP

Vital Signs

04-Jun-2012	Pulse: 80 • Resp: 12 • BP: 120/70 RUE • Temp: 98.6
11-May-2012 02:34PM	Pulse: 58 • Resp: 12 • BP: 124/58 LUE • Temp: 98.6

The Demographics Section

Logan, Arnold Download/Print Search for patient

Upload
 ID: 345634 DOB: 05-Jan-1946 Age/Sex: 66 male
 Address: 654 Broadhead Place • Lexington, KY 40515
 Phone(s): 888-825-4258 (Primary)

Open

Add Notes

Expanding the demographics section will allow the user to input additional demographic data including family members, emergency contacts, and insurance information.

Patient Information

Logan, Arnold
Edit

Patient ID 345634 Gender Male Birth 05-Jan-1946 Age 66

Race/Ethnicity Language

Primary Phys

Contact • Insurance • Legal • Family • Custom

Contact

Home 654 Broadhead Place
Lexington, KY 40515
888-825-4258 (Primary) Edit

Emergency Edit

Pharmacy Edit

Insurance

Plan Group/Policy # Effective Edit

Plan Group/Policy # Effective Edit

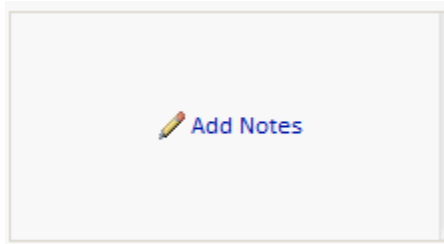
Legal

Exit

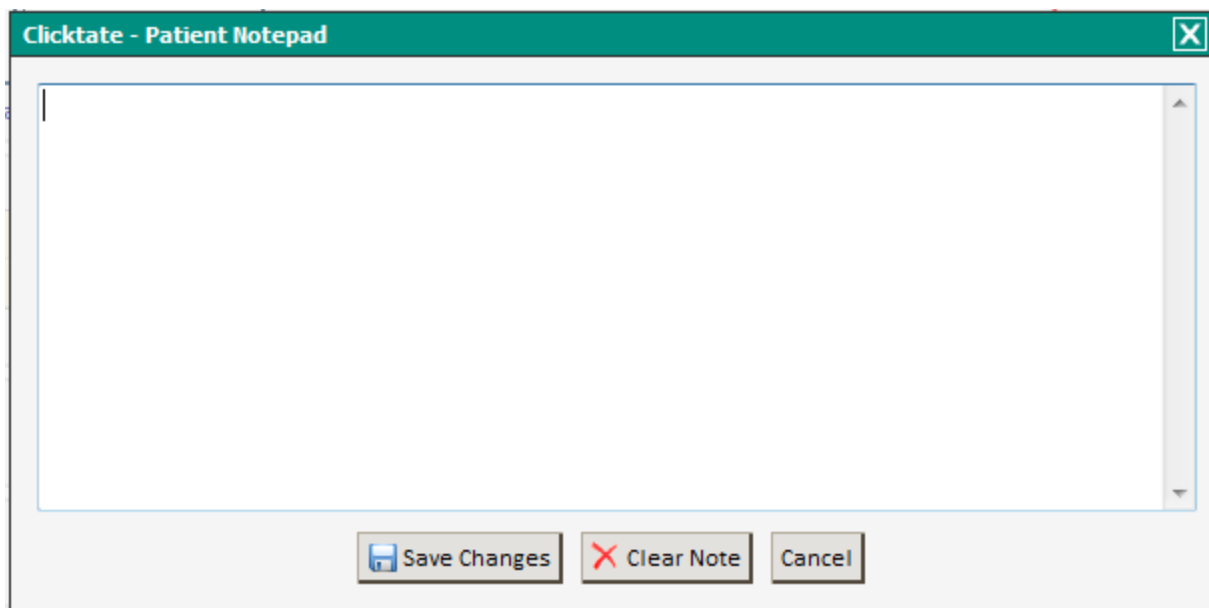
In addition, under the demographics section is an area to include spouse and parents' names and information. Living Wills and Powers of Attorney may also be recorded in this section. These items, if recorded, will be reflected on the face sheet under the demographics section.

The Patient Notepad Section

Immediately to the right of the Demographic information is a Free Text box. This box can be used to record any data that isn't found elsewhere or data that the user wants to notice each time a patient comes to the office.



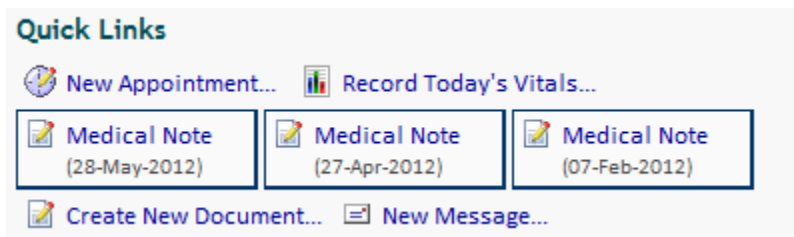
Selecting the "Add Notes" link will open a text box.



The Workflow Section

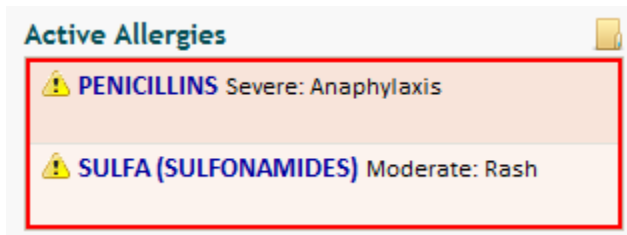
In the workflow section, “Quick Links” are provided for rapid access to:

- The patient’s most recent appointment as found on the scheduling calendar
- Record the current vital signs
- The three most recent **unsigned** notes
- A link to quickly start a new note
- A link to start a new patient message



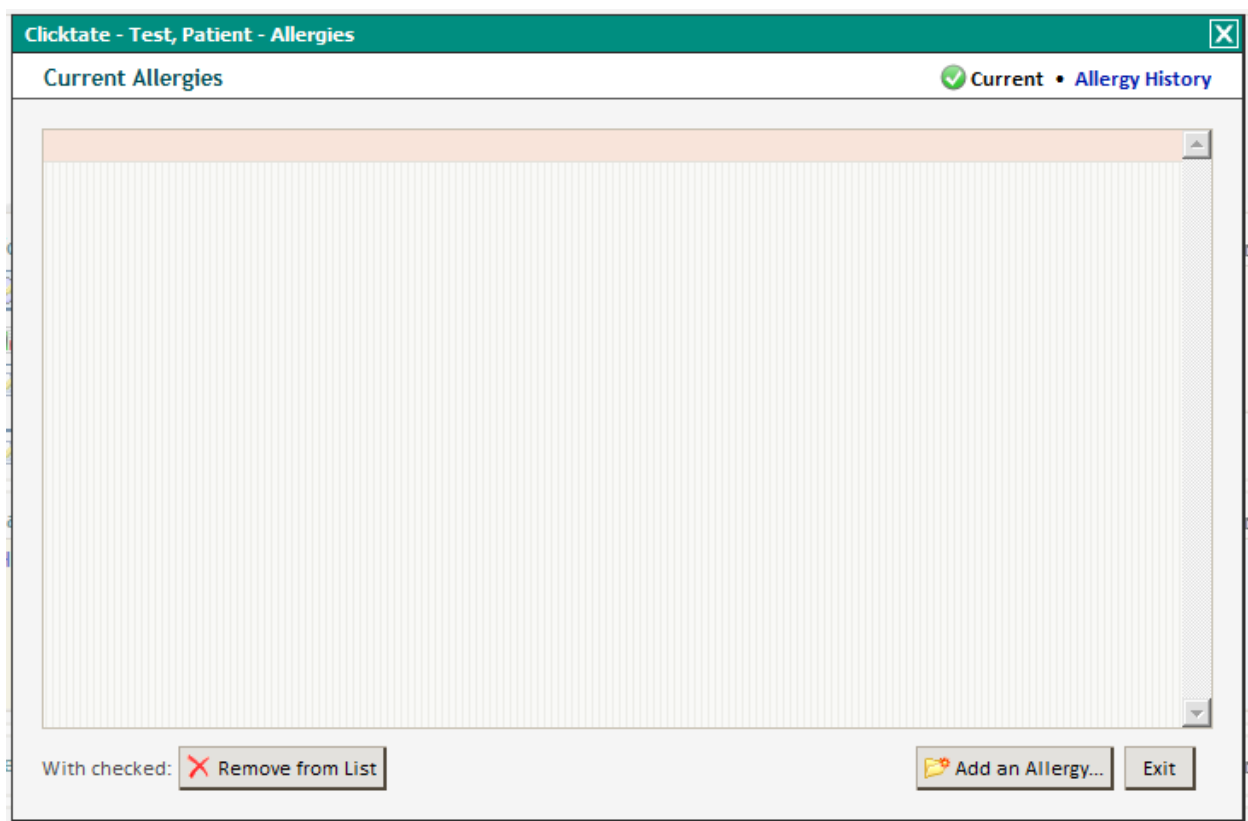
The Allergies Section

The allergies section will allow the quick entry and review of patient allergies and adverse reactions. To add new allergies, select either the expand option or the “(None Known)” designation.



NOTE: The allergy and medication sections will function differently for those users who are E-Prescribing. For information on the allergy and medication sections for e-prescribers, please refer to the e-prescribing section of the manual.

To add a new allergy, select the “Add an Allergy...” button.



Select the medication or type in a new medication in the free text (“other”) box.

Allergies

Penicillin	Amoxicillin	Augmentin	Cephalosporins	Sulfa
Bactrim	Cipro	Erythromycin	NSAIDs	Statins
Codeine	Hydrocodone	Morphine	Latex	Contrast Dye

other

Select Free Text

And then select the reaction and save changes.

Allergies

Reactions for Cipro:

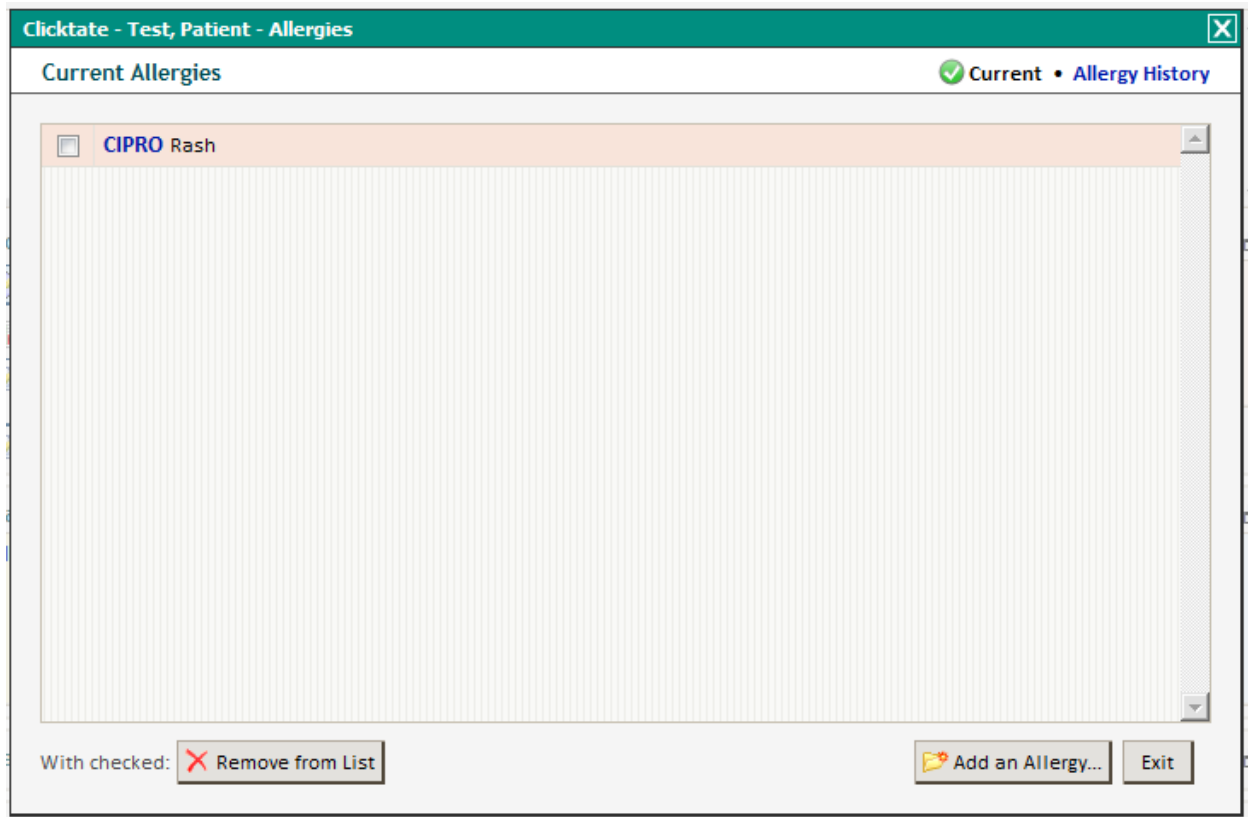
Back

<input checked="" type="checkbox"/> Rash	<input type="checkbox"/> Constipation	<input type="checkbox"/> Breast Pain
<input type="checkbox"/> Itching	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Breast Swelling
<input type="checkbox"/> Hives	<input type="checkbox"/> Cough	<input type="checkbox"/> Urinary Frequency
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Headache	<input type="checkbox"/> Urinary Retention
<input type="checkbox"/> Generalized Swelling	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Swollen Mouth	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Vaginal Dryness
<input type="checkbox"/> Swollen Tongue	<input type="checkbox"/> Syncope	<input type="checkbox"/> Excessive Sedation
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Myalgias
<input type="checkbox"/> Abdominal Upset	<input type="checkbox"/> Bruising	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Nausea	<input type="checkbox"/> Epistaxis	<input type="checkbox"/> Liver Dysfunction
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dysphagia	

☐ other

Save Changes

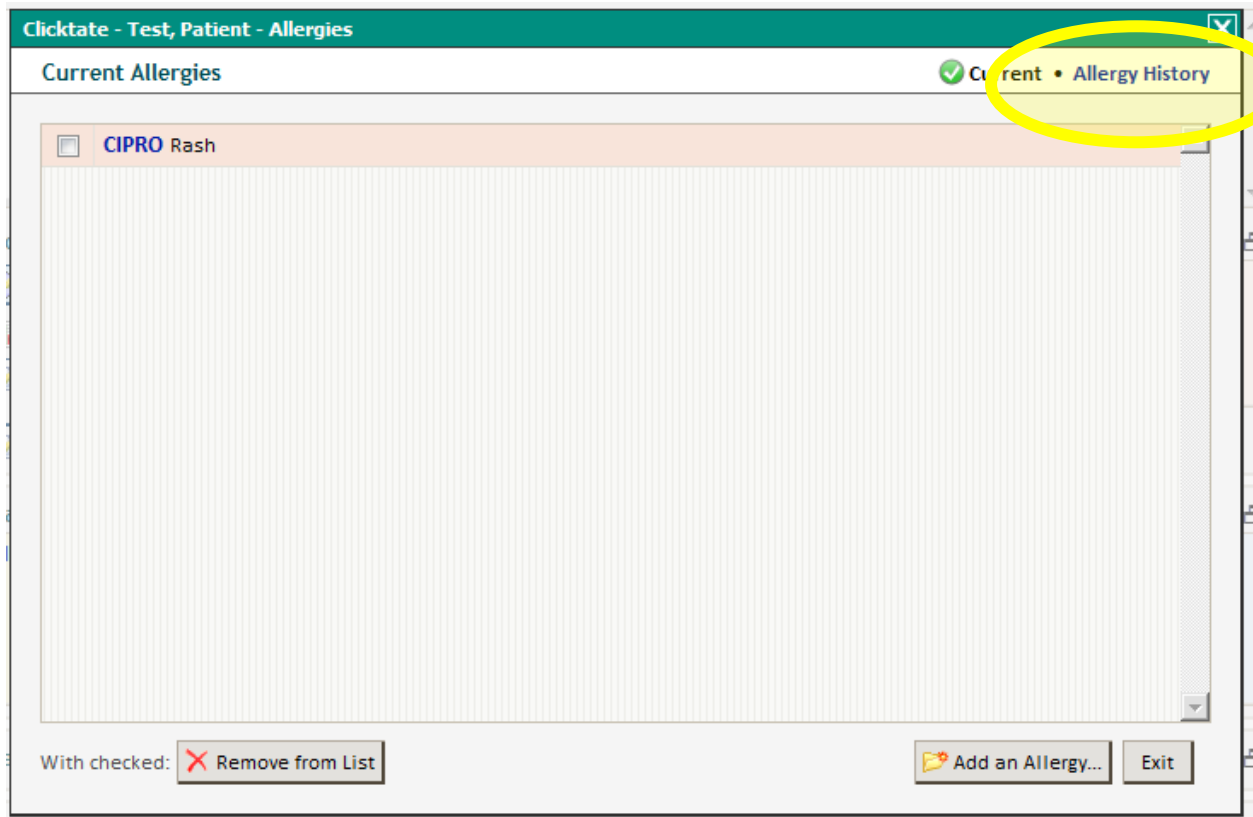
Cancel



The allergy will appear in a highlighted section on the Facesheet and will also automatically be inserted into notes.



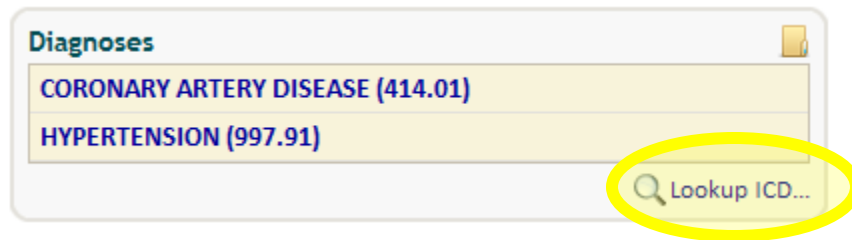
To review the allergy history, select the Allergy History tab on the Allergy Pop-up.



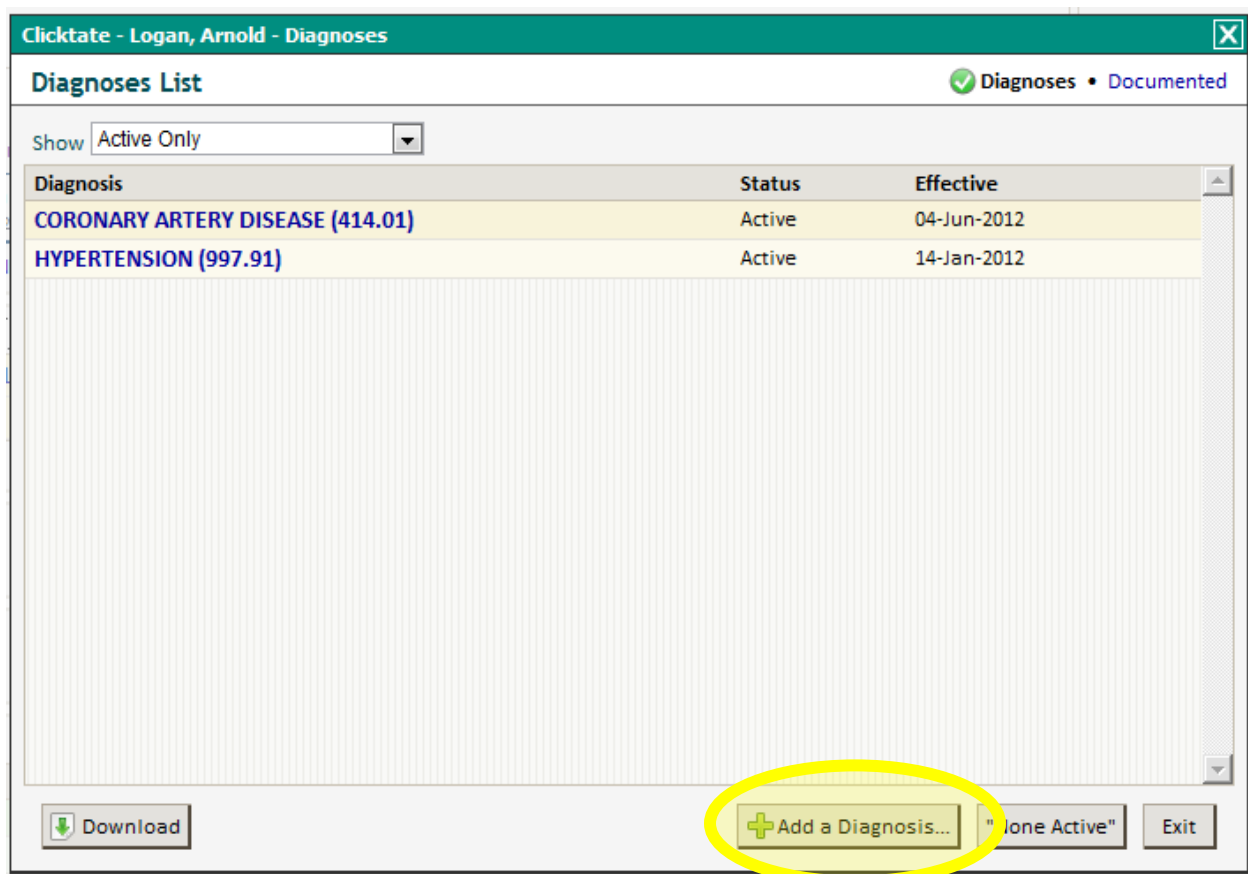
The Allergy History section will render a chronologic list of all allergy information in the chart. It will also give a quick link to notes related to the addition or deletion of any allergy data.

The Diagnoses Section

The diagnoses will automatically populate the Facesheet from notes that are created in Clicktate. ***This applies only to notes that are signed and locked after the release of the Facesheet.*** In addition, diagnoses may be added or changed by using the ICD function found in the diagnosis section.



To add new diagnoses, select either the expand option, the “(None Recorded)” designation or any diagnosis listed in this section.



Selecting the “Add a Diagnosis...” button will open the ICD Pop-up.

Clicktate - Logan, Arnold - Diagnosis Entry

Date: 15-Jun-2012 Status: Active

Description: [Lookup...](#)

ICD: [Lookup...](#)

[Save Changes](#) [Cancel](#)

Diagnoses may be searched for either by the ICD code or by a description. Type a diagnosis description and then press the “Lookup” icon. You may also add diagnoses in free text (non-ICD form) to the chart by simply typing them into the box and immediately selecting “Save Changes”, bypassing the ICD Lookup.

Clicktate - Logan, Arnold - Diagnosis Entry

Date: 15-Jun-2012 Status: Active

Description: hypothyroid [Lookup...](#)

ICD: [Lookup...](#)

[Save Changes](#) [Cancel](#)

Selecting the appropriate diagnosis from the ICD pop-up will place the diagnosis onto the Facesheet.

Clicktate - ICD Codes

Search For
hypothyroid Search...

244 Acquired hypothyroidism
244.0 Postsurgical hypothyroid
244.2 Iodine hypothyroidism
244.3 Iatrogen hypothyroid NEC
244.8 Acquired hypothyroid NEC
244.9 Hypothyroidism NOS
[show all 244.x]

243 Congenital hypothyroidism

Selected Code < Prev | Next >
244 Acquired hypothyroidism

Notes

OK Clear Cancel

Let's select 244.9 Hypothyroidism NOS and Click OK.

Clicktate - ICD Codes

Search For

244 Acquired hypothyroidism
 244.0 Postsurgical hypothyroid
 244.2 Iodine hypothyroidism
 244.3 Iatrogen hypothyroid NEC
 244.8 Acquired hypothyroid NEC
 244.9 Hypothyroidism NOS
[\[show all 244.x\]](#)
243 Congenital hypothyroidism

Selected Code [< Prev](#) | [Next >](#)

244.9 Hypothyroidism NOS

Notes Unspecified acquired hypothyroidism

Clicktate - Logan, Arnold - Diagnosis Entry

Date
 Status

Description

ICD

Saving changes will place the diagnosis in the patient chart. The wording of the diagnosis may be changed if desired. The diagnosis may also be designated as inactive, resolved or rule-out by using the Status menu. The date of diagnosis may also be placed into the record.

Clicktate - Logan, Arnold - Diagnoses

Diagnoses List
✓ Diagnoses • Documented

Show Active Only

Diagnosis	Status	Effective
HYPOTHYROIDISM NOS (244.9)	Active	15-Jun-2012
CORONARY ARTERY DISEASE (414.01)	Active	04-Jun-2012
HYPERTENSION (997.91)	Active	14-Jan-2012

Download
Add a Diagnosis...
None Active
Exit

Diagnoses

HYPOTHYROIDISM NOS (244.9)
CORONARY ARTERY DISEASE (414.01)
HYPERTENSION (997.91)

Lookup ICD...

From within the expanded diagnosis pane, other functions are available to see diagnoses linked to office notes, download a diagnosis list or select “None Active”.

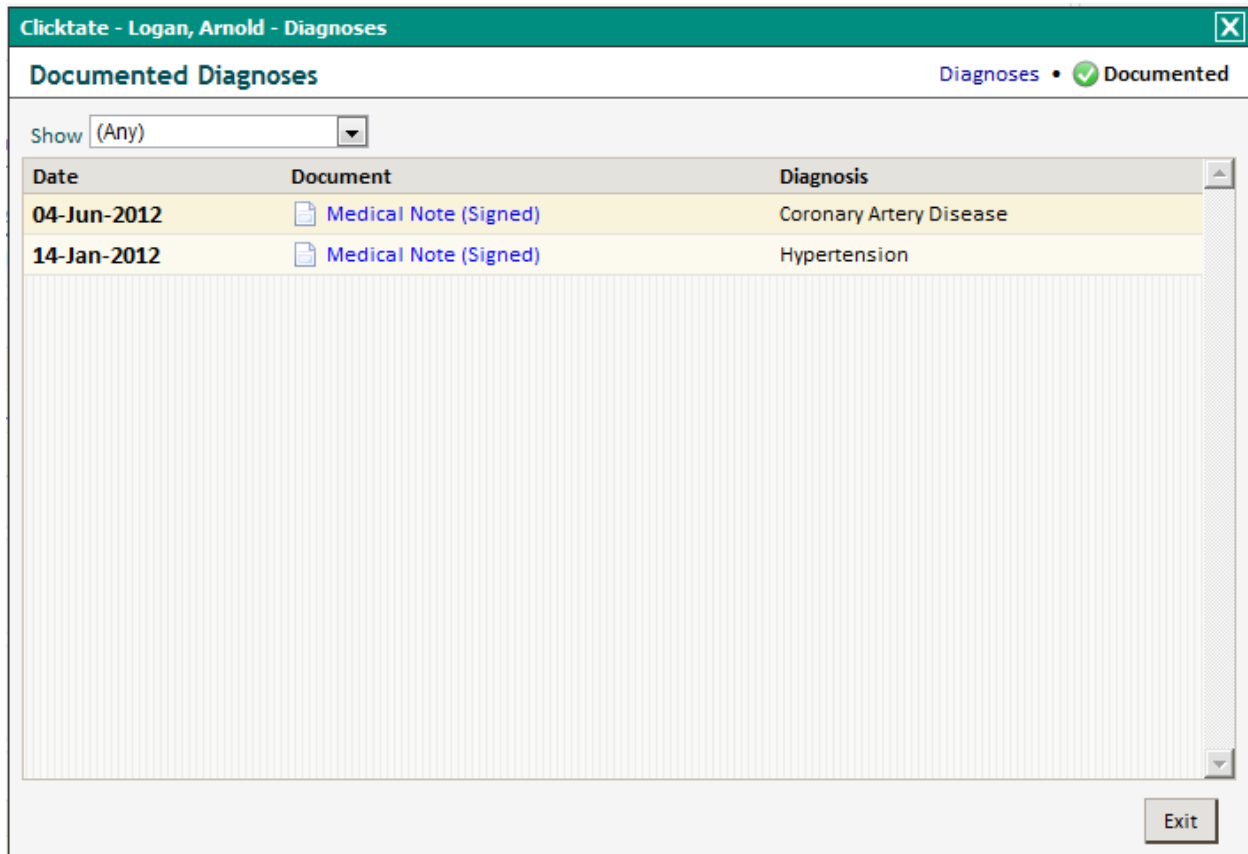
To download a Public Health Surveillance file, select the download button from the expanded Diagnoses List pane. This file may be downloaded as an encrypted or unencrypted file.

File Download

Filename Logan_345634_ADT.hl7
SHA-1 Hash 195b5f62dbe335f8dc2212b4894e18ef99e5586c

Download
Encrypt...
Cancel

By selecting the “Documented” option from the expanded Diagnoses List pane, users may view and open notes where diagnoses were documented.



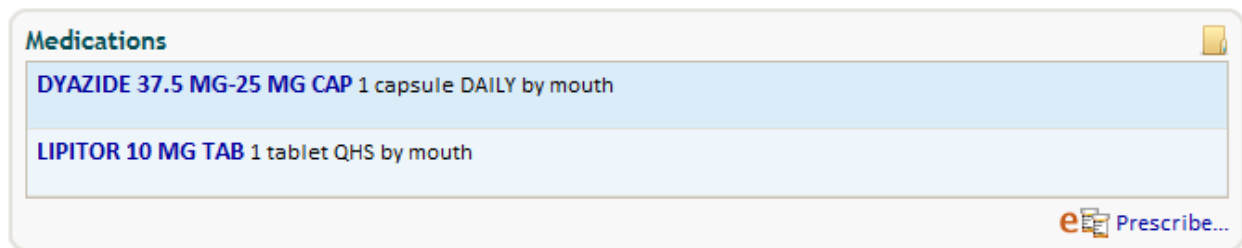
As already stated, diagnoses will also automatically populate the Facesheet from notes generated in Clicktate after the notes are signed and locked by the user.

The Medication Section

From the medication section, it is possible to:

- Add or inactivate medications
- Print a patient medication list
- Write prescriptions
- Review the refill history of a medication
- See the last actions taken for a medication
- Review the notes related to a medication

To work with medications, select the “Expand” link on the medication section of the Facesheet. Any changes made to medications on the Facesheet will be reflected in notes. Any changes to the medications in a signed and locked note will be reflected on the Facesheet.



When the medication list is expanded, the medication list pop-up will appear.

From here a patient medication list may be printed. The patient medication list is printed in a patient understandable manner without abbreviations or jargon that might confuse or not be understood by patients.

LCD Solutions, LLC

New LCD Admin
LCD Headquarters
1-888-825-4258

Medication List for Logan, Arnold

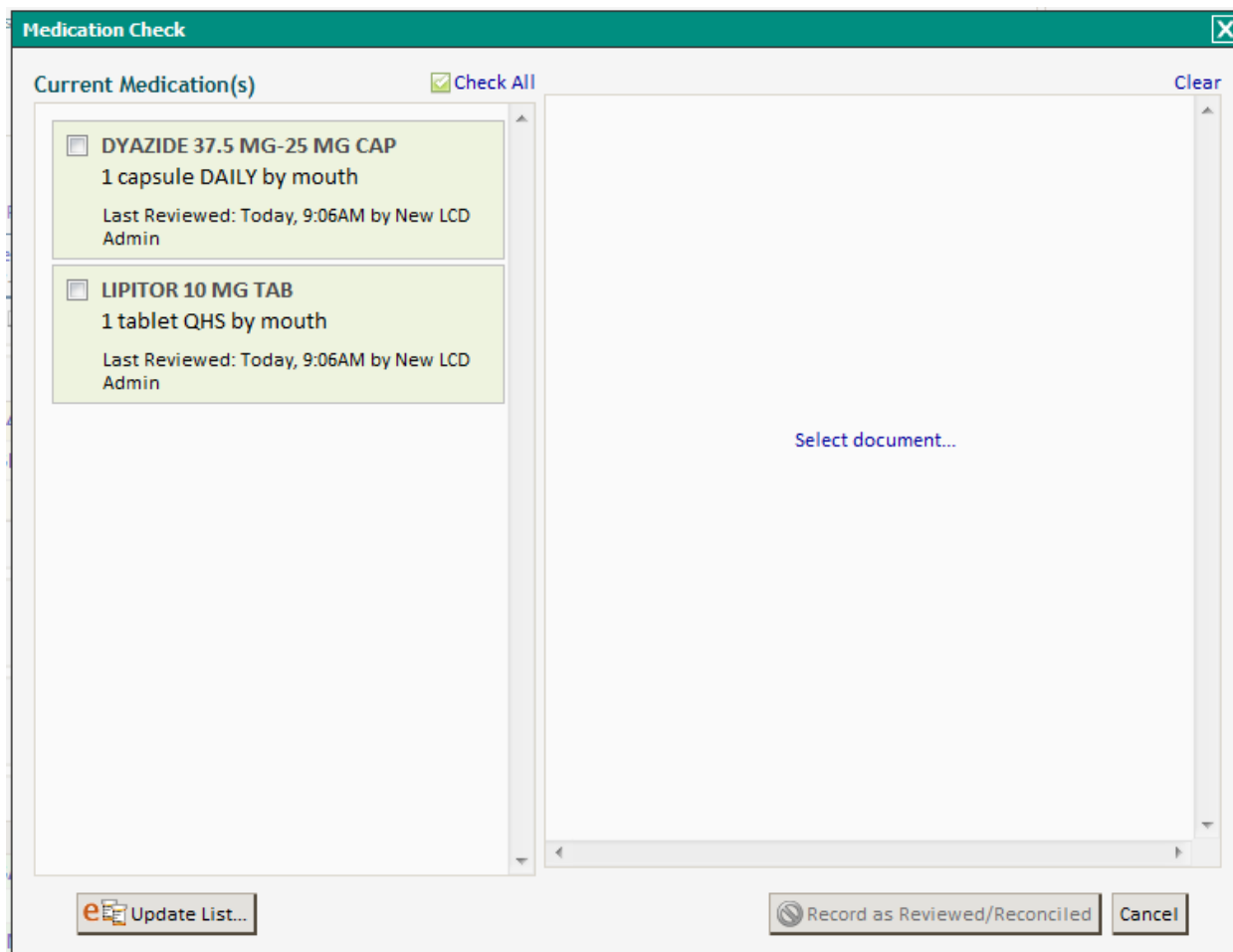
Printed 15-Jun-2012, 6:47PM

MEDICATION	DIRECTIONS
Dyazide 37.5 mg-25 mg Cap	1 capsule daily by mouth
Lipitor 10 mg Tab	1 tablet at bedtime by mouth

To see a medication history of a given medication, select the medication name from the history on the left.

Clicktate - Logan, Arnold - Medications			
Medication History		Current • History	
Date	Action: Medication	RX	Source
14-Jan-2012	Added: Dyazide 37.5 mg-25 mg Cap	Disp: 30, Refills: 2	NewCrop
	Added: Lipitor 10 mg Tab		NewCrop
Exit			

The “Review/Reconcile...” feature allows a side-by-side comparison of the current medication list in Clicktate with another medication list from another note, a hospital summary or another provider.



The image shows a software window titled "Medication Check" with a close button (X) in the top right corner. The window is divided into two main panes. The left pane is titled "Current Medication(s)" and contains a list of two medications, each with a checkbox and a "Check All" button. The first medication is "DYAZIDE 37.5 MG-25 MG CAP" with instructions "1 capsule DAILY by mouth" and "Last Reviewed: Today, 9:06AM by New LCD Admin". The second medication is "LIPITOR 10 MG TAB" with instructions "1 tablet QHS by mouth" and "Last Reviewed: Today, 9:06AM by New LCD Admin". The right pane is currently empty and contains the text "Select document...". At the bottom of the window, there are three buttons: "Update List..." (with a small icon), "Record as Reviewed/Reconciled" (with a circular arrow icon), and "Cancel".

Medication Check [X]

Current Medication(s) [Check All] [Clear]

- ☐ **DYAZIDE 37.5 MG-25 MG CAP**
1 capsule DAILY by mouth
Last Reviewed: Today, 9:06AM by New LCD Admin
- ☐ **LIPITOR 10 MG TAB**
1 tablet QHS by mouth
Last Reviewed: Today, 9:06AM by New LCD Admin

Select document...

[Update List...] [Record as Reviewed/Reconciled] [Cancel]

A document that has been scanned or created in Clicktate may be selected for a side-by-side comparison. Once all medications are in agreement, select “Record as Reviewed/Reconciled” and the system will record the date and time that the reconciliation occurred.

The Clinical Decision Support Section

The clinical decision support section of Clicktate is design to allow the tracking of “routine” tests for health maintenance and screening, as well as patient specific tests related to a patient’s disease conditions.

Clinical Decision Support		
Item	Frequency	Last Recorded
<input checked="" type="checkbox"/> BMP WITH DIURETIC USAGE	Every 1 year(s)	(None)
<input checked="" type="checkbox"/> COLONOSCOPY	Every 10 year(s)	(None)
<input checked="" type="checkbox"/> PROSTATE EXAMINATION	Every 1 year(s)	(None)
<input checked="" type="checkbox"/> PSA	Every 1 year(s)	(None)
<input checked="" type="checkbox"/> TETANUS BOOSTER	Every 10 year(s)	(None)
<input checked="" type="checkbox"/> AAA SCREENING	N/A	(None)
<input checked="" type="checkbox"/> ASPIRIN USAGE RECOMMENDED	N/A	(None)

Expanding this section allows data to be input regarding a test, filtering of tests, and the addition of more tests to the list. A comprehensive set of Clinical Decision Support rules are included in Clicktate. These rules are disease and demographic specific and are automatically applied to the appropriate patient population.

Current Clinical Decision Support rules may be accessed from the Report menu found at the top of most pages in Clicktate.



The image shows the top navigation bar of the Clicktate application. The Clicktate logo is on the left. To its right is a horizontal navigation menu with links: Home, Patients, Documents, Sched, Track, Scan, Lab, Report, and NO. The 'Report' link is highlighted with a yellow oval. Below the navigation bar, the user's name 'Logan, Arnold' is displayed. Further down, patient information is shown: ID: 345634, DOB: 05-Jan-1946, Age/Sex: 66 male, and Address: 654 Broadhead Place • Lexington, KY 40515.

Reporting

Type: Clinical Decision Support	
Name	Description
<input checked="" type="checkbox"/> AAA Screening	Ultrasound Abd Aorta: A one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 years who have ever smoked is recommended.
<input checked="" type="checkbox"/> ACE Inhibitors in Patients with Congestive Heart Failure	ACE inhibitors are recommended for routine administration to symptomatic and asymptomatic patients with left ventricular ejection fraction (LVEF) \leq 40%.
<input checked="" type="checkbox"/> ACE Inhibitors or ARBs in Diabetic Patients	ACE or ARB in DM: Use of ACE Inhibitor or Angiotensin Receptor Blocker is recommended for Diabetic Patients
<input checked="" type="checkbox"/> Advanced Directives	Advanced Directives: Record Advanced Directives for patients aged 65 and older
<input checked="" type="checkbox"/> Aspirin Usage Recommended	Aspirin Use Recom Men: Aspirin usage is recommended in men age 45-79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
<input checked="" type="checkbox"/> Aspirin Usage Recommended	Aspirin Use Recom Women: Aspirin usage is recommended in women age 55-79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
<input checked="" type="checkbox"/> Beta Blocker Therapy in Patients with Congestive Heart Failure	Beta-blockers shown to be effective in clinical trials of patients with HF are recommended for patients with an LVEF \leq 40%. The combination of a beta blocker and an ACE inhibitor is recommended as routine therapy for asymptomatic patients with a LVEF \leq 40%. Beta blocker therapy is recommended for patients with a recent decompensation of HF after optimization of volume status and successful discontinuation of intravenous diuretics and vasoactive agents, including inotropic support. Whenever possible, beta blocker therapy should be initiated in the hospital setting at a low dose prior to discharge in stable patients. Beta blocker therapy is recommended in the great majority of patients with HF and reduced LVEF, even if there is concomitant diabetes, chronic obstructive lung disease, or peripheral vascular disease.
<input checked="" type="checkbox"/> BMP with Diuretic Usage	BMP: Patients on diuretics should be considered for a metabolic panel to include BUN, Creatinine and Potassium yearly or more frequently as clinically warranted.
<input checked="" type="checkbox"/> Chlamydia Screening	Chlamydia Vaginal: It is recommended to screen for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
<input type="button" value="New Report..."/>	

Reporting

Type	Clinical Decision Support
Cholesterol for Hyperlipidemia	Colonoscopy: Colonoscopy Suggested Every 10 years for Patients over 50 years old. (May be suggested more frequently for patients with certain diagnoses or a family history of colon polyps or colon malignancy.)
Colonoscopy	Examination Ophthalmology: Patients with diabetes should receive a dilated eye examination on a yearly basis
Diabetic Eye Examination	DM Nephropathy Screening: Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of 5 years and in all type 2 diabetic patients, starting at diagnosis.
Diabetic Nephropathy Screening	Creatinine: Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate glomerular filtration rate (GFR) and stage the level of chronic kidney disease (CKD), if present.
Diabetic Serum Creatinine Measurement	PT INR: Patients on chronic coumadin or warfarin therapy should have an INR at a minimum of every four weeks and possibly more frequently depending on clinical circumstances.
INR Due to Coumadin Usage	Mammogram-Screen: Biennial mammography is recommended for women between the ages of 50-74. A discussion should be undertaken with younger women regarding mammography between the ages of 40-50. Physicians should discuss with each woman the potential benefits and harms of breast cancer screening tests and develop a plan for early detection of breast cancer that minimizes potential harms. These discussions should include the evidence regarding each screening test, the risk of breast cancer, and individual patient preferences.
Mammogram	It is recommended that a Pap smear be completed at least every 3 years to screen for cervical cancer for women who have ever had sex and have a cervix. (NOTE: This report is set with a default of EVERY 3 YEAR PAP SMEARS. To change the default for individual patients update the report on the patient's Facesheet in the Clinical Decision Support Section.)
Pap Smear	Pneumococcal Vaccine: Patients over age 65 should have a pneumococcal vaccination.
Pneumococcal Vaccination	Examination Prostate: The current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years. The current evidence recommends against screening for prostate cancer in men age 75 years or older. THIS CLINICAL DECISION SUPPORT ITEM ADDS A DIGITAL PROSTATE EXAMINATION YEARLY. TO DEACTIVATE SELECT FROM THE CDS MENU AND DESELECT.
Prostate Examination	

Additional tests and procedures may be added to this list and are PRACTICE SPECIFIC.

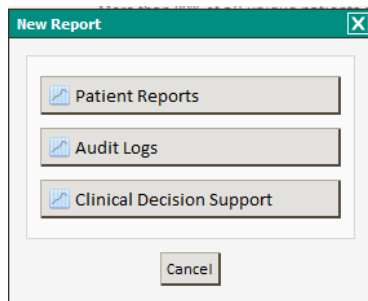
Adding a Clinical Decision Support Rule

To add a Clinical Decision Support Rule for a practice, first select Report from the top menu. Then select "New Report..."

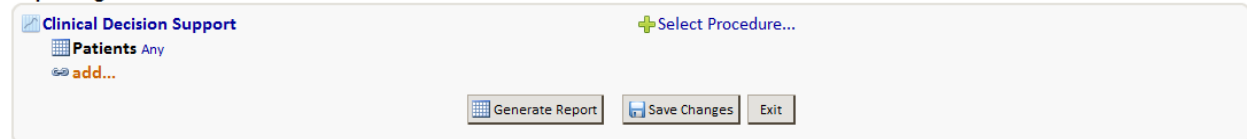
Reporting

Type	(Any)
Name	Description
A1C with Zip	
Cholesterol for Hyperlipidemia	Cholesterol Check every year for those with hyperlipidemia
HG	
HIV Disease	Patients diagnoses with HIV or AIDS
Lipitor	
MU: Active Medication Allergy List	More than 80% of all unique patients seen by the EP have at least one entry or an indication that the patient has no known medication allergies recorded as structured data
MU: Active Medication List	More than 80% of all unique patients seen by the EP have at least one entry or an indication that the patient is not currently prescribed any medication recorded as structured data.
MU: Advanced Directives Recorded	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital have an indication of an advance directive status recorded
MU: Clinical Lab Test Results	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
MU: Clinical Summary Provided	Clinical Summaries provided to patients for more than 50% of all office visits within 3 business days.
MU: CPOE for Medication Orders	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Prescriber details and a printable list of all prescriptions written may be found in the administration section of the electronic prescribing module.
MU: Electronic Copy of Health Information	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days
MU: Generate Permissible Prescriptions Electronically	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
MU: Patient Specific Education Resources	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient -specific education resources
MU: Preventive Care Reminder Sent	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
MU: Provide Timely Electronic Access	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
MU: Record and Chart Changes in Vital Signs	More than 50% of all unique patients age 2 and over seen by the EP have height, weight and blood pressure recorded as structured data
MU: Record Demographics	More than 50% of all unique patients seen by the EP have demographics recorded as structured data

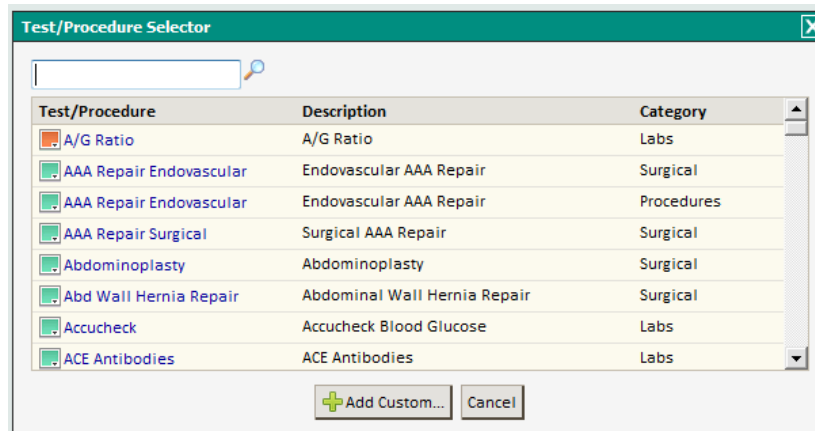
Select “Clinical Decision Support”.



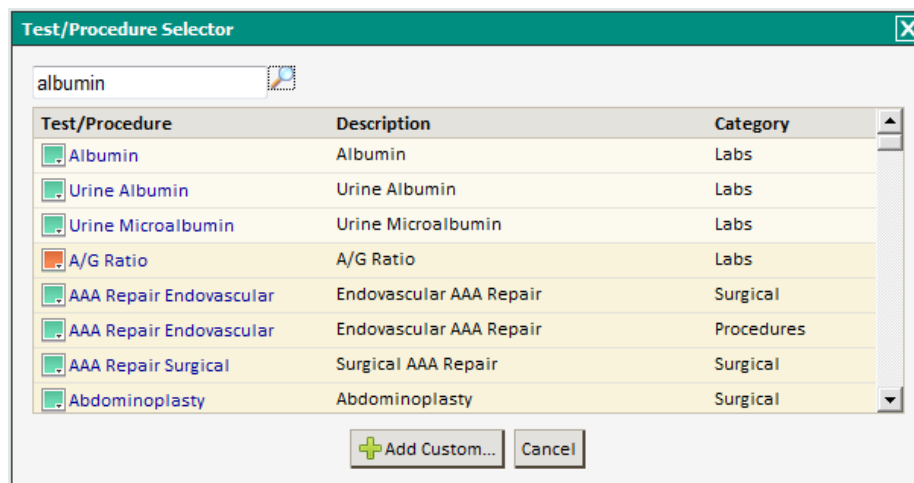
Reporting



Select “+Select Procedure...” and the Procedure selector appears.



The items denoted by a green icon are generic to the system. The items denoted by a red icon are practice specific icons. From this menu, select the item for which a Clinical Decision Support rule is desired. Searching for Albumin gives the following result:



Choosing “Albumin” from the list will allow Albumin to be tied to a Clinical Decision Support and any number of conditions, demographics, medications or other criteria.

Reporting

The screenshot shows a 'Reporting' window with a sidebar on the left containing 'Clinical Decision Support', 'Patients Any', and 'add...'. The main area is titled 'Albumin' and features an 'Interval' checkbox, a text input field with 'every', and a dropdown menu set to 'day(s)'. At the bottom are three buttons: 'Generate Report', 'Save Changes', and 'Exit'.

In addition, a time interval for applying the rule may also be implemented. To implement a rule to apply Albumin every three months, simply check the interval box and input the interval.

Reporting

This screenshot is similar to the previous one, but the 'Interval' checkbox is now checked. The text input field contains the number '3', and the dropdown menu is set to 'month(s)'.

The Clinical Decision Support Rule may be renamed by selecting “Clinical Decision Support”. In addition, a description may be entered.

The 'Report Entry' dialog box has a title bar with a close button. It contains two text input fields: 'Name' with the text 'Clinical Decision Support' and 'Description' which is currently empty. At the bottom are 'Save Changes' and 'Cancel' buttons.

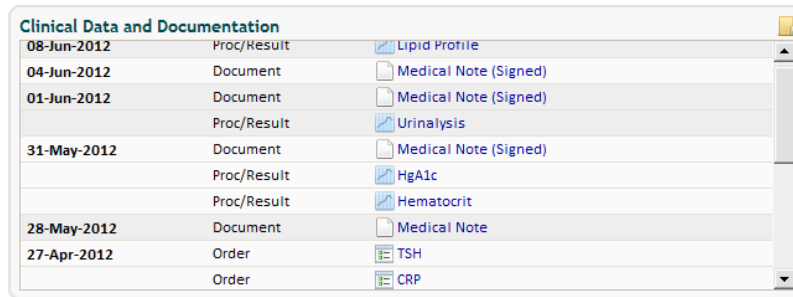
A large yellow arrow points from the 'Report Entry' dialog box above to this one. In this updated version, the 'Name' field contains 'Albumin in Diabetic Pts' and the 'Description' field contains the text: 'This is a rule to remind providers to check an albumin in diabetic patients as part of an ongoing clinical trial throughout our organization.' The 'Save Changes' and 'Cancel' buttons are at the bottom.

To see a list of every patient who is due for a Clinical Decision Support item, choose the item from the Clinical Decision Support list or select Generate List from within the specific Clinical Decision Support window.

Creating Clinical Decision Support Rules is tied to the Reports section of Clicktate. An in-depth discussion of creating reports is found in the Reporting Chapter of this manual.

The Clinical Data and Documentation Section

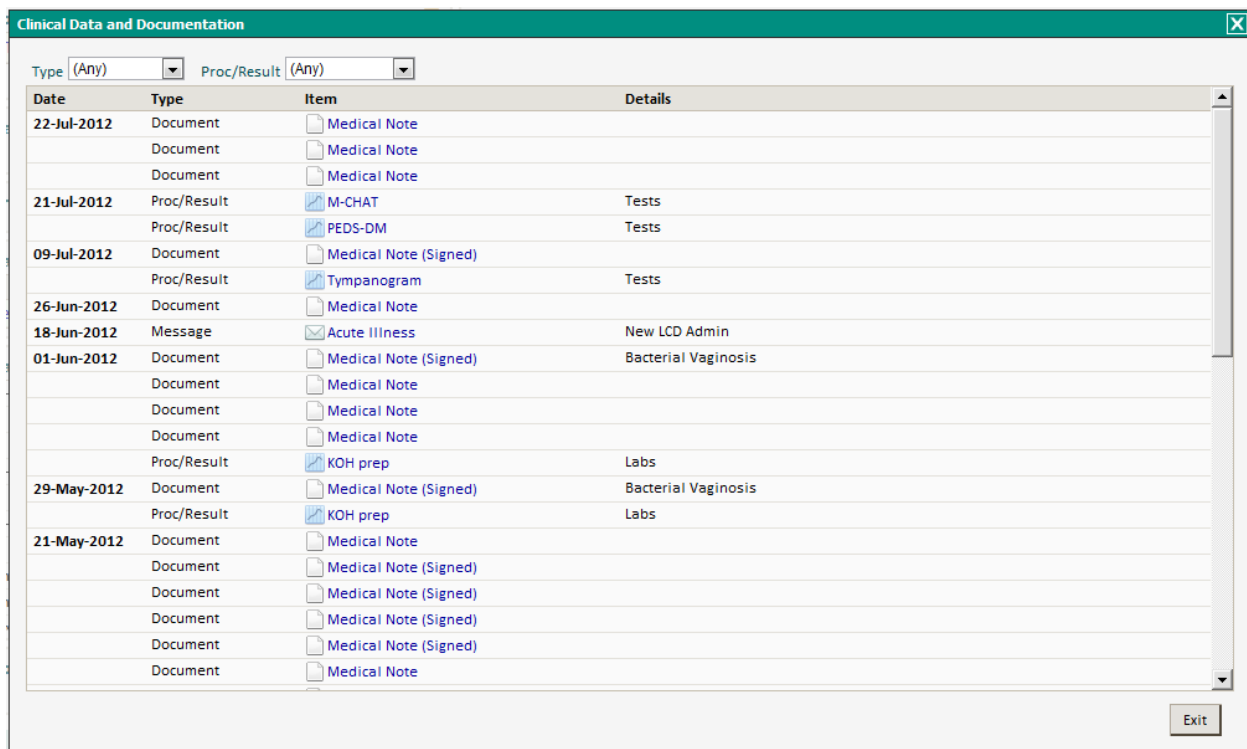
In the Clinical Data and Documentation section, users will find a chronologic “running” list of all data in the patients chart. The list may be filtered and sorted.



Clinical Data and Documentation

08-Jun-2012	Proc/Result	Lipid Profile
04-Jun-2012	Document	Medical Note (Signed)
01-Jun-2012	Document	Medical Note (Signed)
	Proc/Result	Urinalysis
31-May-2012	Document	Medical Note (Signed)
	Proc/Result	HgA1c
	Proc/Result	Hematocrit
28-May-2012	Document	Medical Note
27-Apr-2012	Order	TSH
	Order	CRP

Expanding the section will allow the user to filter notes based on multiple criteria.



Clinical Data and Documentation

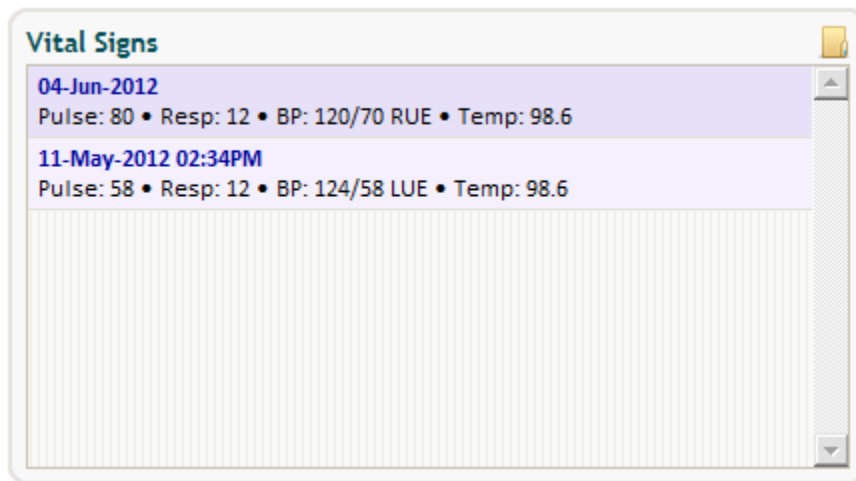
Type (Any) Proc/Result (Any)

Date	Type	Item	Details
22-Jul-2012	Document	Medical Note	
	Document	Medical Note	
	Document	Medical Note	
21-Jul-2012	Proc/Result	M-CHAT	Tests
	Proc/Result	PEDS-DM	Tests
09-Jul-2012	Document	Medical Note (Signed)	
	Proc/Result	Tympanogram	Tests
26-Jun-2012	Document	Medical Note	
18-Jun-2012	Message	Acute Illness	New LCD Admin
01-Jun-2012	Document	Medical Note (Signed)	Bacterial Vaginosis
	Document	Medical Note	
	Document	Medical Note	
	Document	Medical Note	
	Proc/Result	KOH prep	Labs
29-May-2012	Document	Medical Note (Signed)	Bacterial Vaginosis
	Proc/Result	KOH prep	Labs
21-May-2012	Document	Medical Note	
	Document	Medical Note (Signed)	
	Document	Medical Note (Signed)	
	Document	Medical Note (Signed)	
	Document	Medical Note (Signed)	
	Document	Medical Note	

Exit

The Vital Signs Section

This is the section where vital signs may be entered, saved and reviewed.

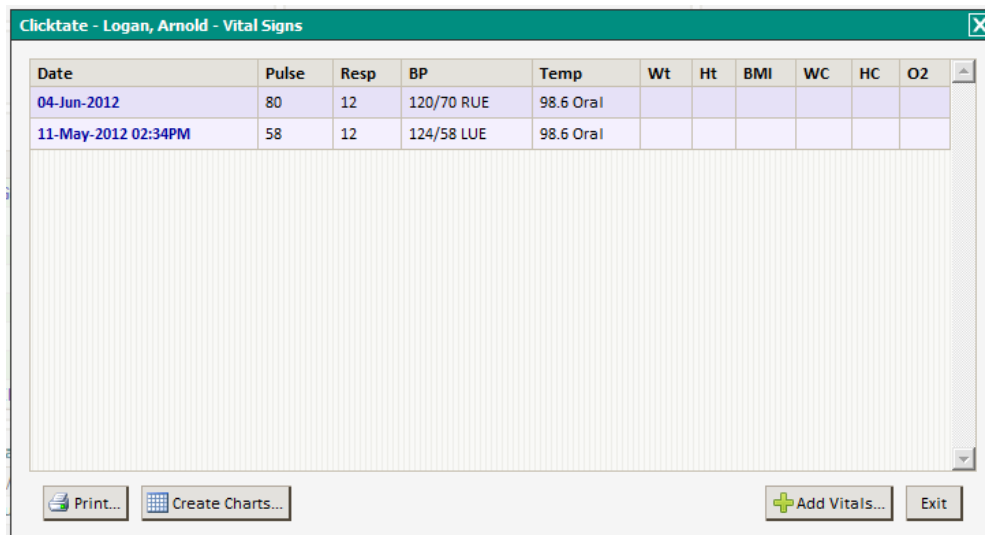


Vital Signs

04-Jun-2012
Pulse: 80 • Resp: 12 • BP: 120/70 RUE • Temp: 98.6

11-May-2012 02:34PM
Pulse: 58 • Resp: 12 • BP: 124/58 LUE • Temp: 98.6

This section may be expanded to the Vitals pop-up.

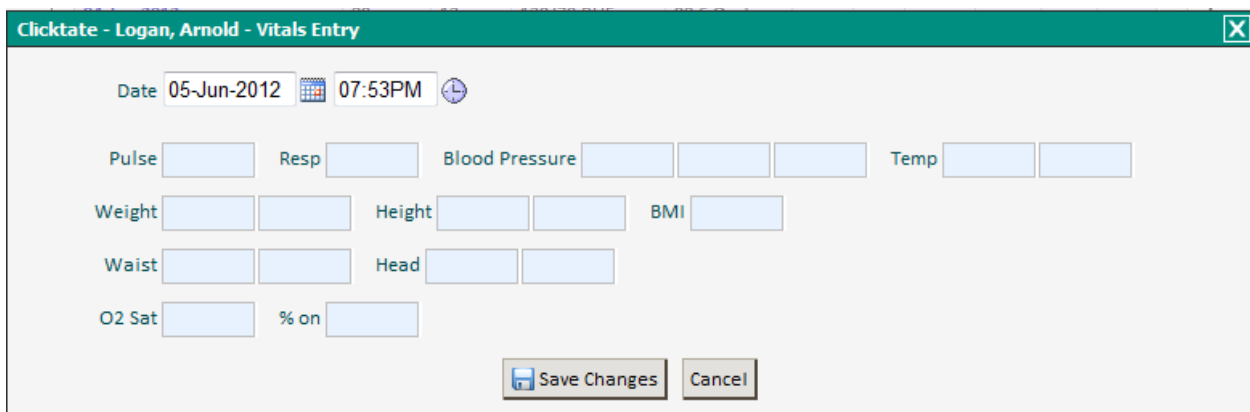


Clicktate - Logan, Arnold - Vital Signs

Date	Pulse	Resp	BP	Temp	Wt	Ht	BMI	WC	HC	O2
04-Jun-2012	80	12	120/70 RUE	98.6 Oral						
11-May-2012 02:34PM	58	12	124/58 LUE	98.6 Oral						

Print... Create Charts... +Add Vitals... Exit

To add vital signs from a visit, select the “+Add Vitals...” button.



Clicktate - Logan, Arnold - Vitals Entry

Date: 05-Jun-2012 07:53PM

Pulse: Resp: Blood Pressure: Temp:

Weight: Height: BMI:

Waist: Head:

O2 Sat: % on:

Save Changes Cancel

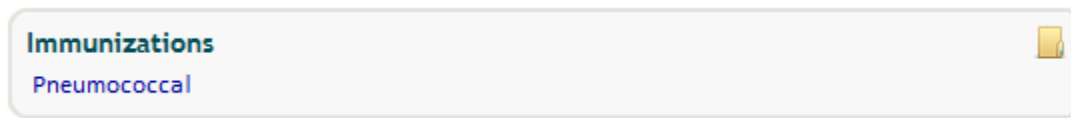
Vital signs that are added will automatically populate into the note. The BMI (Body Mass Index) will automatically calculate if the Height and Weight are added. Any changes to the vital signs that are made in a note will reflect on the vitals table once the note is signed and locked.

To add multiple or repeated vitals on the same day, enter a new set of vitals and use the “Time” stamp to input the time that the vital signs were recorded. MULTIPLE SETS OF VITAL SIGNS FROM THE SAME DAY SHOULD BE ENTERED ON THE FACE SHEET.

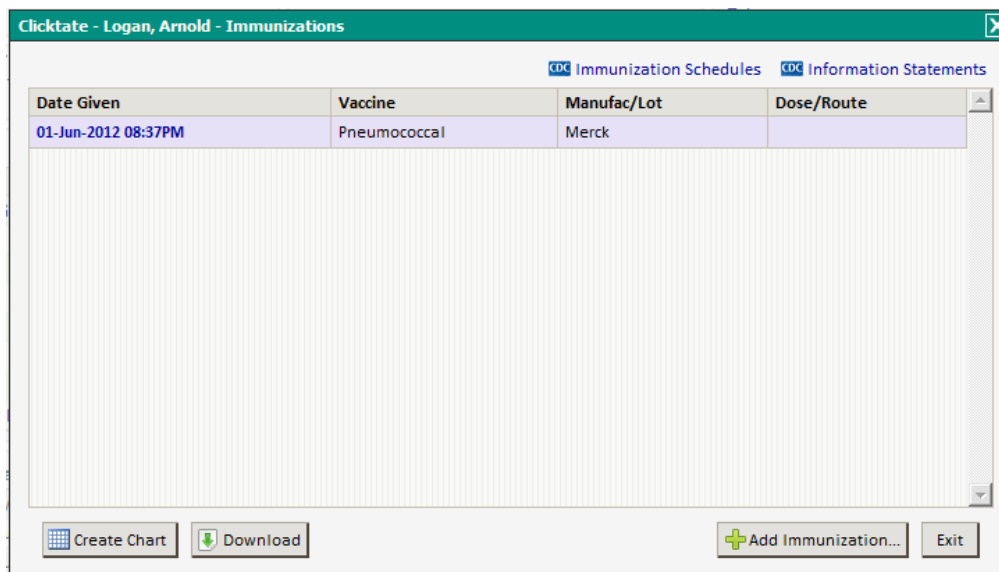
To view Growth Charts or Graphs of other Vital Signs, select the “Create Charts...” link on the vital sign pop-up. WHO and CDC growth charts may be plotted.

The Immunization Record

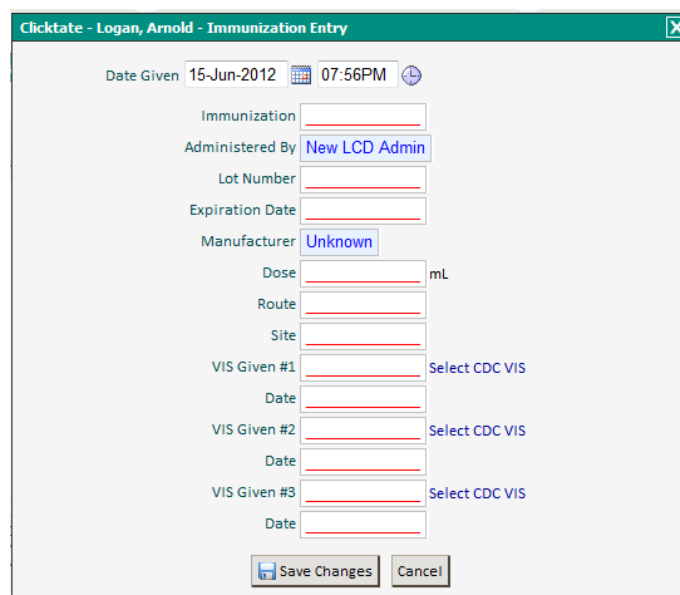
Immunizations may be recorded and tracked from the Facesheet Immunization section.



Selecting Immunizations will open the immunization record. From here, immunizations may be entered, immunization charts may be created, and the CDC immunization schedules may be accessed.

A screenshot of a software window titled "Clicktate - Logan, Arnold - Immunizations". At the top, there are two tabs: "CDC Immunization Schedules" and "CDC Information Statements". Below the tabs is a table with four columns: "Date Given", "Vaccine", "Manufac/Lot", and "Dose/Route". The first row of the table contains the text "01-Jun-2012 08:37PM", "Pneumococcal", "Merck", and an empty field. Below the table is a large empty area. At the bottom of the window, there are four buttons: "Create Chart", "Download", "Add Immunization..." (with a green plus icon), and "Exit".

Choosing "Add Immunization..." will open the immunization entry field where new immunization information may be entered.

A screenshot of a software window titled "Clicktate - Logan, Arnold - Immunization Entry". The window contains several input fields and buttons. At the top, there are two date and time pickers: "Date Given" set to "15-Jun-2012" and "07:56PM". Below these are input fields for "Immunization", "Administered By" (with a dropdown menu showing "New LCD Admin"), "Lot Number", "Expiration Date", and "Manufacturer" (with a dropdown menu showing "Unknown"). There are also input fields for "Dose" (with a unit "mL" next to it), "Route", and "Site". Below these are three sections for "VIS Given #1", "VIS Given #2", and "VIS Given #3", each with a "Date" input field and a "Select CDC VIS" button. At the bottom of the window are two buttons: "Save Changes" and "Cancel".

CDC Vaccine Information Sheets (VIS) may be accessed and printed from this page as well.

Section X: Electronic Prescribing

Users who elect Electronic Prescribing (e-prescribing) will be able to receive prescription refill requests directly from pharmacies, transmit refill requests directly to pharmacies, check drug-drug interactions, check drug-allergy interactions, check drug-disease interactions, provide medication information to patients and check formulary status of prescribed medications.

Clicktate™ has partnered with NewCrop, LLC to provide an easy to use, fully integrated state of the art e-prescribing system. NewCrop is a Surescripts™ Gold Solution certified electronic prescribing provider. Gold Solution Provider status recognizes physician technology vendors that are advancing electronic prescribing and healthcare interoperability with customers in the United States. This certification is designed to recognize physician technology vendors' products that leverage the complete resources and capabilities of Surescripts and its network to improve the safety, efficiency and quality of the prescribing process.

Electronic prescribing will require certification and verification of licensure and DEA status. Please contact us directly for details regarding activation of e-prescribing.

In addition, electronic prescribing will require a free 1-2 hour training session which is accomplished via webinar. The average set-up and training time for electronic prescribing is 4-6 hours.

The cost and set-up for e-prescribing is included in the price structure of Clicktate. Additional or advanced set-up options may be billed an excess hourly service fee of \$70 per hour.

Legacy Medications

Historical (Legacy) medications and allergies currently in Clicktate™ will need to be transferred to the NewCrop system.

When you enter the Facesheet of a patient who has Legacy medications and/or allergies, a banner will appear at the top of the screen alerting you to this fact. In addition, the Legacy medications and allergies will appear in ***Italicized Red Type***.

The screenshot displays the Clicktate™ TEST patient interface. At the top, a yellow banner states: "This patient has legacy medications/allergies that may need to be transferred to our partner ePrescribing system. Click here to do this now." The patient's name is John, Jimmy. Key information includes ID: 239480, DOB: 14-Sep-1954, Age: 56, and Address: 45678 Sesame Seed Lane, McDonaldLand, CA 90210. The workflow section offers options like "New Appointment...", "Record Today's Vitals...", and "Medical Note" (with dates 22-Dec-2009, 20-Dec-2009, and 18-Dec-2009). The "Active Allergies" section lists "CIPRO Swollen Mouth • Abdominal Pain" in red italics. The "Diagnoses" section shows "HYPERLIPIDEMIA" in blue. The "Current Medications" section lists "PREVACID (30MG) 1 daily" and "TOPROL-XL (EQ 25MG TARTRATE) 1 daily" in red italics. The interface also includes a "Print" button and a "Search for patient" field.

By selecting a legacy medication, a legacy allergy or the alert banner, the e-prescribing module will be accessed and the medications and allergies will transfer to this area.

The patients name, address and pharmacy information must be present in Clicktate™ in order to access the e-prescribing system.

The Med Entry page of the NewCrop system will include the Legacy Medications and Allergies.

Return to Clickstate

LCD Solutions, LLC
 Pharm: 1 Fax: 0 Pend: 0

Select Dr./Staff Compose Rx **Med Entry** Pt. Details Pt. Notes Diagnoses Admin

LCD Solutions, LLC/Resources New LCD Admin
Designated On/Prescriber: **New LCD Admin**

Face Sheet
Patient: **Jimmy John** DOB: **9/14/1954** Gender: **Male**
Self Pay/No Insurance Selected

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking.
Delete

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	""		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily 30			N	""		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor

Enter Original Start Date
 Month Day Year

Drug Search
Doctor's List

3 letter min. 5 recommended ☐ Include obsolete drugs

Allergy / Intolerance Search
🔍

No Allergies have been entered.

memo

Imported Allergies: not included in Drug Review
Delete

Click to include

Name	Severity	Notes	Delete
Cipro		Swollen Mouth - Abdominal Pain	<input type="checkbox"/>

Current Medications for Jimmy John
☐ Takes No Meds

☐ Discontinued / Previous
 ☐ Cancelled Mid-Process
 ☐ Pharmacy Communication

Tinted Rx are external: entered via MedEntry or imported, source shown.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking.
Delete

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	""		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily 30			N	""		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor

Enter Original Start Date
 Month Day Year

Drug Search
Doctor's List

3 letter min. 5 recommended ☐ Include obsolete drugs

Allergy / Intolerance Search
🔍

No Allergies have been entered.

memo

Imported Allergies: not included in Drug Review
Delete

Click to include

Name	Severity	Notes	Delete
Cipro		Swollen Mouth - Abdominal Pain	<input type="checkbox"/>

Current Medications for Jimmy John
☐ Takes No Meds

☐ Discontinued / Previous
 ☐ Cancelled Mid-Process
 ☐ Pharmacy Communication

Tinted Rx are external: entered via MedEntry or imported, source shown.

To transfer a medication to the NewCrop system, select the medication from the Imported Rx list.

Selecting a medication from the Imported Rx list will open the Drug Search Results window.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking.
Delete

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	***		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	***		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor

Enter Original Start Date

Month
Day
Year

Drug Search
Doctor's List

3 letter min. 5 recommended
☐ Include obsolete drugs

Drug Search Results
Close

Prevacid
(Lansoprazole)
[Monograph](#)
[Leaflet](#)
Peptic Ulcer - Proton Pump Inhibitors

[Prevacid 15 mg Cap](#) (Generic Available)

[Prevacid 30 mg Cap](#) (Generic Available)

Prevacid 24Hr
(Lansoprazole)
[Monograph](#)
[Leaflet](#)
Peptic Ulcer - Proton Pump Inhibitors

[Prevacid 24Hr 15 mg Cap](#) OTC(Generic Available)

Prevacid IV
(Lansoprazole)
[Monograph](#)
[Leaflet](#)
Peptic Ulcer - Proton Pump Inhibitors

[Prevacid IV 30 mg Solution](#)

Prevacid SoluTab
(Lansoprazole)
[Monograph](#)
[Leaflet](#)
Peptic Ulcer - Proton Pump Inhibitors

[Prevacid SoluTab 15 mg Rapid Dissolve](#)

[Prevacid SoluTab 30 mg Rapid Dissolve](#)

[Click here if drug not found.](#)

Select the appropriate medication for the Drug Search Results list.

The selected medication will appear in the Current Meds edit list.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking.

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	****		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	****		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor

Enter Original Start Date
Month Day Year

or leave for further processing

	Rx Date Stage	Drug	Sig	#	Refill	Doc / Loc Source			
<input checked="" type="checkbox"/>	01/29/11 InProc	Prevacid 30 mg Cap			0	Admin	<input type="button" value="EDIT"/>		<input type="button" value="X"/>

3 letter min. 5 recommended
☐ Include obsolete drugs

No Allergies have been entered.

memo

Imported Allergies: not included in Drug Review

Click to include

Name	Severity	Notes	Delete
Cipro		Swollen Mouth - Abdominal Pain	<input type="checkbox"/>

Current Medications for Jimmy John
☐ Takes No Meds

☐ Discontinued / Previous
☐ Cancelled Mid-Process
☐ Pharmacy Communication

Tinted Rx are external: entered via MedEntry or imported, source shown.

Selecting the "Edit" tab beside the medication will open the medication edit page.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking. Delete

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	***		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	***		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor: Enter Original Start Date: Month Day Year

Select to Move to Current Meds or leave for further processing Adjust Disp# only after completing Sig.

Prevacid 30 mg Cap Dosing

1	capsule	by mouth	Select Frequency	#	Capsule	0
<div>1</div> <div>1-2</div> <div>1-3</div> <div>2-3</div> <div>0.5/half</div> <div>1.5</div> <div>2</div> <div>2.5</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>15</div> <div>20</div> <div>30</div>	<input type="checkbox"/> PRN <input type="checkbox"/> DAW / DNS <input type="checkbox"/> One Time <input type="checkbox"/> Save this sig and add to Doctor's List		<div>Select Frequency</div> <div>as directed</div> <div>DAILY</div> <div>BID</div> <div>TID</div> <div>QID</div> <div>Q4h</div> <div>Q6h</div> <div>Q8h</div> <div>Q12h</div> <div>NIGHTLY</div> <div>BEDTIME</div> <div>in A.M.</div> <div>Q2h WA</div> <div>EVERY OTHER DAY</div> <div>3 TIMES WEEKLY</div> <div>Q1wk</div> <div>Q2wks</div> <div>Q3wks</div> <div>Once a month</div> <div>Add'l Sig</div>	<div>7 day</div> <div>10 day</div> <div>14 day</div> <div>21 day</div> <div>30 day</div> <div>90 day</div> <div>Days Supply</div> <div>0</div> <div><input type="checkbox"/> 2nd rx</div> <div>90 Day</div>	<div>Select packaging for pharmacist</div> <div>Available packaging</div> <div>80 each BLIST PACK</div> <div>7 each BOTTLE</div> <div>10 each BOTTLE</div> <div>14 each BOTTLE</div> <div>Save Rx</div> <div>Cancel</div>	<div>Refills</div> <div>0</div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div>

Additional Sig: (will appear on rx label)

Pharmacist Message: (will NOT appear on rx label - no sig allowed)

Select Diagnosis

Enter the appropriate medication information and select "Save Rx".

Select to Move to Current Meds		or leave for further processing				Open Edit for Dosing			
	Rx Date Stage	Drug	Sig	#	Refill	Doc / Loc Source			
<input checked="" type="checkbox"/>	01/29/11 InProc	Prevacid 30 mg Cap	1 daily	30	5	Admin	EDIT		X

Next select "Select to Move to Current Meds". The medication now appears on the current medication list.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking.									Delete
Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete	
12/24/09	PREVACID (30MG)	1 daily			N	""		<input type="checkbox"/>	
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	""		<input type="checkbox"/>	

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor Enter Original Start Date
 Month Day Year

Drug Search

3 letter min. 5 recommended ☐ Include obsolete drugs

No Allergies have been entered.

memo

Imported Allergies: not included in Drug Review			
Click to include			
Name	Severity	Notes	Delete
Cipro		Swollen Mouth - Abdominal Pain	<input type="checkbox"/>

Select **Current Medications for Jimmy John** Drug Review

	Rx Date Stage	Drug	Sig	#	Refill	Doc / Loc Source			
<input type="checkbox"/>	01/29/11	Prevacid 30 mg Cap	1 daily	30	5	Admin	<input type="button" value="EDIT"/>		<input type="checkbox"/>

☐ Discontinued / Previous ☐ Cancelled Mid-Process ☐ Pharmacy Communication

Tinted Rx are external: entered via MedEntry or imported, source shown.

The same approach may be taken with other medications on the Imported Rx list. If a medication isn't listed after the search of the database, a help screen will appear.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking. Delete								
Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	""		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	""		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor Enter Original Start Date
 Month Day Year

Drug Search Doctor's List

3 letter min. 5 recommended ☐ Include obsolete drugs

Drug Search Results Close

Your requested drug has not been found:

- **Miss-spelled?....try fewer letters.** Search is performed on the full entry for an exact match only. A spelling error at the 5th letter will result in a null search. Try fewer letters. 3-4 are usually enough.
- **Too many results?....**"Hydrocortisone" comes in tablets, tubes, OTC: hundreds of ways. Add more information. ie. hydrocortisone 10 to find a 10mg tablet.
- **Too much information?.... leave off the chemical suffix.** The drug list uses chemical suffixes only when there are multiple forms of a drug: i.e. when clinically relevant. For instance, erythromycin will show estolate and ethyl succinate, and each appears. In contract, "hydrocodone tartrate" will not be found because *tartrate* is not clinically relevant. Search as "hydrocodone".
- **Obsolete Drug?.... use the check box.** The drug list shows only currently available drugs. Recently pulled drugs will not show on routine search, but will show if the "Search Obsolete Drugs" box is checked. Note, these drugs are retained for a few months only and then drop of the obsolete list also.
- **Missing Brand?..... try an ingredient search.** Older drugs may still be available generically when the brand is no longer marketed. I.e. Elavil will not show, but amitriptyline will.
- **Missing OTC/Herbal?.....** The brand names on these are variable and too numerous to track. With few exceptions, however, searching the ingredient will find the product. Read the label!!
- **Really missing?** This is possible only if you have the RxNorm drug index. (Most accounts have First Data Bank.) Check the bottom of the Review Page to see if you have RxNorm and report the missing drug: customersupport@newcroprx.com. We will correct the data base. In the meantime, record the rx using the Orders link, upper left hand side of the page.
- **Experimental or foreign?** Only US FDA-approved drugs appear for selection. (Non-US users will see their respective list.) To add unlisted drugs to the patient record, use the Orders link on the upper left of the page.
- **Canada formulations.....** RxNorm users may see a formulation not marketed in the US. Let us know, and we will label it as such: customersupport@newcroprx.com

[Click here if drug not found.](#)

Select the "Click here if drug not found" link OR try typing in an alternative spelling in the Drug Search box.

Drug Search		Doctor's List
<input type="text" value="Toprol"/>	<input type="checkbox"/> Include obsolete drugs	
3 letter min. 5 recommended		
Drug Search Results		Close
Your requested drug has not been found:		
<ul style="list-style-type: none"> • Miss-spelled?....try fewer letters. Search is performed on the full entry for an exact match only. A spelling error at the 5th letter will result in a null search. Try fewer letters. 3-4 are usually enough. 		

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking. Delete

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	****		<input type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	****		<input type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor Enter Original Start Date
 Month Day Year

Drug Search Doctor's List

3 letter min. 5 recommended ☐ Include obsolete drugs

Drug Search Results Close

Toprol XL
 (Metoprolol Succinate) [Monograph](#) [Leaflet](#) Beta Blockers Cardiac Selective

Toprol XL 100 mg 24 hr Tab	(Generic Available)
Toprol XL 200 mg 24 hr Tab	(Generic Available)
Toprol XL 25 mg 24 hr Tab	(Generic Available)
Toprol XL 50 mg 24 hr Tab	(Generic Available)

[Click here if drug not found.](#)

Select the appropriate medication and enter the dosing as before. Once all Legacy medications are transferred to the NewCrop system, you may check the delete box and delete the medications from the Imported Rx list. Alternatively the medications may be retained on this list for reference.

Imported Rx: Drugs are not in Interaction/Allergy/Condition/Formulary checking. Delete

Rx Date	Drug	Sig	Dispense	Refills	DAW	Reported Dr.	Memo	Delete
12/24/09	PREVACID (30MG)	1 daily			N	****		<input checked="" type="checkbox"/>
12/24/09	TOPROL-XL (EQ 25MG TARTRATE)	1 daily	30		N	****		<input checked="" type="checkbox"/>

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

To transfer Legacy allergy information to the NewCrop system, select the Allergy from the imported allergy list.

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor Enter Original Start Date Month Day Year

Drug Search **Doctor's List**

3 letter min. 5 recommended ☐ Include obsolete drugs

Allergy / Intolerance Search

No Allergies have been entered.

memo

Imported Allergies: not included in Drug Review

Click to include **Delete**

Name	Severity	Notes	Delete
Cipro		Swollen Mouth - Abdominal Pain	<input type="checkbox"/>

Allergy / Intolerance Search **Close**

Enter at least 3 letters of drug or non-drug allergy to search:

Cipro **Search For Allergy**

Click on drug/intolerance to select.

- Cipro
- Cipro HC
- Cipro I.V.
- Cipro in D5W
- Cipro XR
- CIPRODEX
- Ciprofloxacin

[Click here](#) to add a non-drug allergy if not found.

Select **Current Medications for Jimmy John** **Drug Review** **D / C**

	Rx Date Stage	Drug	Sig	#	Refill	Doc / Loc Source			
<input type="checkbox"/>	01/29/11	Toprol XL 50 mg 24 hr Tab	1 daily	30	5	Admin	EDIT		<input type="checkbox"/>
<input type="checkbox"/>	01/29/11	Prevacid 30 mg Cap	1 daily	30	5	Admin	EDIT		<input type="checkbox"/>

From the Allergy/ Intolerance Search box, make the appropriate selection.

Allergy Detail **Close**

Adjust severity or enter additional information then save.

Cipro Select Severity

Previous note may appear. Delete as needed and enter an additional note.

Swollen Mouth - Abdominal Pain

Save/Add Additional Allergy **Save Allergy**

Select a severity level. Reactions will transfer from Clicktate™ into the Note section. Once the severity has been entered from the dropdown list, select “Save Allergy” or “Save/Add Additional Allergy”.

Enter optional Outside Doctor and/or Original Start Date before selecting drug.

Replace current doctor Enter Original Start Date Month Day Year

Drug Search

3 letter min. 5 recommended ☐ Include obsolete drugs

Allergy / Intolerance Search

Allergy	Severity	
Cipro	Moderate	memo

Select **Current Medications for Jimmy John** Drug Review

	Rx Date Stage	Drug	Sig	#	Refill	Doc / Loc Source			
<input type="checkbox"/>	01/29/11	Toprol XL 50 mg 24 hr Tab	1 daily	30	5	Admin	<input type="button" value="EDIT"/>	<input type="button" value="Search"/>	<input type="checkbox"/>
<input type="checkbox"/>	01/29/11	Prevacid 30 mg Cap	1 daily	30	5	Admin	<input type="button" value="EDIT"/>	<input type="button" value="Search"/>	<input type="checkbox"/>

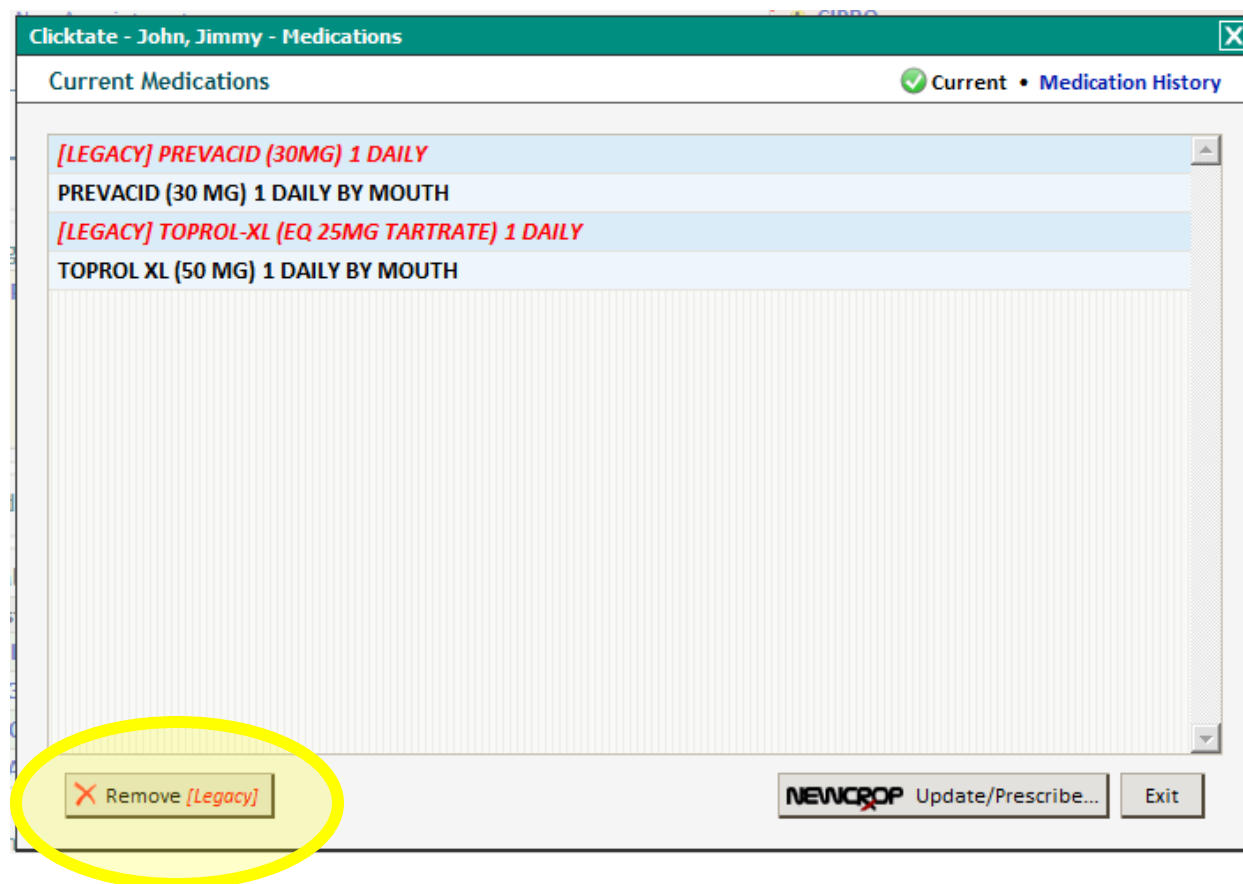
☐ Discontinued / Previous ☐ Cancelled Mid-Process ☐ Pharmacy Communication

Tinted Rx are external: entered via MedEntry or imported, source shown.

Selecting the Magnifying glass icon beside a medication will give historical and refill information.

Select	Current Medications for Jimmy John						Drug Review	<input type="button" value="D / C"/>	
	Rx Date Stage	Drug	Sig	#	Refill	Doc / Loc Source			
<input type="checkbox"/>	01/29/11	Toprol XL 50 mg 24 hr Tab	1 daily	30	5	Admin	<input type="button" value="EDIT"/>	<input type="button" value="Search"/>	<input type="checkbox"/>
<input type="checkbox"/>	01/29/11	Prevacid 30 mg Cap	1 daily	30	5	Admin	<input type="button" value="EDIT"/>	<input type="button" value="Search"/>	<input type="checkbox"/>

Upon returning to Clicktate™, the medication list will now contain both Legacy and NewCrop entered medications. After a final reconciliation to assure that all medications are correct, the Legacy medications may be removed.



How to Write a Prescription

Powered by NewCrop

Welcome.

These pages provide an overview of your new e-rx system. Although our pages are designed to be easy to use, electronic prescribing is inherently different than the rx-on-paper. **We strongly suggest that, at the very least, these 5 pages be completely reviewed prior to prescribing, or watch the video on the Admin Page.** (Button names are denoted with <....>) Most of you will enter e-rx from your EMR. *(Direct user's information will be italicized.)*

Doctors: for best results, we suggest that initial use of e-rx be by your office staff. This will build drug, rx, pharmacy and healthplan lists as refills are processed. Bonus: direct staff to view the Renewal Processing videos on the Admin Page. The Accept/Send feature allows staff to predetermine where an rx goes with your one-click approval. Transform office workflow!!!!

If you are not used to accessing software over the Internet:

- **Save all entries!! A page must be activated to record your information.**
Typing or selecting on a page will not be recorded in the patient record unless **<Save>** or the appropriate activating button is clicked.
- **Don't use the browser Back button.** This will cause you to loose any unsaved information and may show a stored page that is no longer accurate. Use buttons or links on the page to change tasks.
- **Maximize work space:** F11 will do this on most browsers
- **Funny looking page?** Check your browser settings for text size, etc.
- **Button not working?** Check the open window display at the bottom of the screen. A window can open behind another and be hidden.

Training and Help

Videos and illustrated pages are posted on the Admin Page. For more detail, each page has

a **Help** link at the bottom. (The Help pages are compiled in the **Reference Manual**, posted on the Admin Page. Use the customersupport@.... address at the bottom of the page for any remaining questions.

Look for user tips to the right of the title bars:

Patient Education *Use Control key to multiselect and add text as needed*

The Navigaton Bar

The NavBar at the top of each page provides a quick way to change tasks/pages. Note, your name, the current user on the left and the current **Designated Doctor/Prescriber**, whose name will go at the top of the prescription, to the right. (Make a change on **Select Staff** (or *Select Patient*) Page or, for nurses, with the drop-down on the Compose Rx page.) To the left, the [RxHub/RxHistory](#) may appear: click to view an all-doctor Rx history from the patient's healthplan. **Pt. Dx** displays the patient's diagnosis list. **Admin** has reports and other supporting functions. **IMPORTANT:** **Pt Details** is where the patient's preferred pharmacy can be set to automatically receive all approved rx....(1 click for you. Many steps for the rx.)

The Location/Resources Page

This page is accessed by clicking the link to the left of the Nav Bar. Use for a drug reference and to change locations as needed. NOTE: for multiple Location/Workgroups, you will see all prescriptions written by all doctors within your practice from all locations. Be sure and follow your office policy as to when to process an Rx from another location or doctor. If locations are missing, contact your Account Manager.

The Status Page

The Status link, above the NavBar, goes to the Status page, listing all prescriptions needing further processing. **Pharmcom** = electronic pharmacy renewal requests. **Faxes Needing Attention** = those that did not transmit correctly. **Failed Electronic Rx** will also be listed and require reprocessing. **Pending** = Rx that have not been completely processed. Pending Rx can be in one of 3 stages. **DR** has been assigned by staff for a doctor to review. **NS** has been reviewed and approved by a doctor but still needs staff to send to a pharmacy. **InProc**, incompletely processed, has been left unfinished by the displayed user. Any prescriptions left on the Status Page at the end of the day represent "unfinished business."

Access to a Patient: Only the current patient, the selected patient from the EMR, is available for processing on the Status page. (*Direct users can process all.*) Exceptions are re-faxing and NS, both of which are already part of Current Meds.

Compose Rx Page

Displaying the patient's **Current Medications** and any **Pending Prescriptions**, this page is the center of the prescribing process. Mid-page, note **Allergies**.

Start the prescribing process by looking up a drug. Type 3 or more letters and click **<Drug Search/List>**. Upon selection, the drug will appear as an InProc incomplete **Pending Rx** at the top of the page. Drug or formulary links allow further choices at this point. Use the **<Doctor's List>** for multiple selections from your previously prescribed drugs. Delete seldom used drugs to keep the list manageable.

To complete an Rx, click Edit. Select number, sig, and adjust the directions or pre-calculated 30-day supply as needed. Check PRN or DAW (dispense as written). Check **"90 days"** to generate an additional 3 month Rx. Enter any **additional sig** such as insulin dosing for the Rx label. For dose-packs, tubes, insulin etc, select from displayed Packaging for the pharmacist. (Data standards allow only digits in the Disp# field.) Add any additional directions for the pharmacist. **<Save>** your changes. Change your mind by clicking **Cancel**. Note **Save this Sig** check box. This adds the complete rx to search results and the Doctor's List for reuse. The **Dosing** feature is accessed by clicking below the drug name on the left. **One-Time** denotes a med not for chronic use.

Current Medications can also be selected for renewal by checking the boxes to the left and clicking **<Select>**, or select a single rx by clicking.

Pending Prescriptions are part-way through the process but have not yet been added to the patient's Current Medication list. To reiterate, these come in several Stages: 1) Newly selected or left unfinished at any point= **InProc**. 2) Rx left by Clinical Staff for doctor review = **DR**. An Rx that has been approved by the doctor and left for staff processing = **NS**.

To continue, choose **<Proceed to Review>** to access the The Review Page with multiple processing options. To instantly send the rx, click **<Approve/Send>**. It will auto-process as predetermined by patient and staff preferences. These are set in Pt. Details and RxDetail.

-

<Approve/Send) will automatically send an rx to any pharmacy, email a patient, send your denial to office staff or any combination thereof. All routing information is pre-entered from the Pt. Detail and RxDetail pages, then activated with a single click. .

The **Instant Renewal** button below the Current Medications will send multiple rx directly to the patient's pharmacy, bypassing the ability to print leaflets and other optional steps.

Current Medications can have multiple **Sources**. (1) prescriptions written by all doctors within your account are displayed with the Location. (Your current Location is bolded.) (2) medications entered by staff from the Med Entry page (3) additional prescription records that may have been loaded from outside sources such as RxHub, RHIO, or IPA. Click Edit to the right of a Current Med to record a sig change. To discontinue a drug or eliminate duplicate records, use the check boxes and **<D/C>**. At the bottom of the page are links accessing **Discontinued Medications**, **Cancelled Prescriptions** , and a log of the patient's **Pharmcom** activity, including denied renewals.

Imported Rx may also appear above Pending when information for full processing is not available. These are not used for drug review!! Convert to a Current Med by clicking and selecting from the search results.

Experimental Drug entry is done via the Orders link at the top left of the page.

When entering a new patients current medication or those prescribed outside your practice, use the Medentry Page via the Navigation Bar. Additionally, non-clinical staff can enter and leave an rx for further processing by doctor or clinical staff.

The Review Page

Interactions and allergies comparing the Pending Prescriptions to the patient's Current Medications and each other are displayed. If this is an RxHub patient, drug interactions are automatically checked against a 90 day all-doctor history as well. The **Drug/Condition check** is activated when ICD or V codes (i.e pregnancy) are passed from your EMR (*or entered on the Pt Dx page.*) Delete an offending drug and/or select a next step at the

bottom. **<Approve/Leave for Staff>** allows doctors to “sign off,” leaving the batch to the staff list on the Status Page as an **NS** for further processing. (Nurses may select **<Leave for Doctor Review>**), placing it on the Doctor’s review list on the Status Page.

The Batch Concept

Note the check boxes to the left of the meds being processed. On this and subsequent pages, un-checking a box splits the batch for separate processing. For instance, Schedule 2 drug must be printed, while the rest of the batch can be transmitted to the pharmacy.

Routing Page and Printing Prescriptions


A batch of prescriptions ready for printing or transmission is displayed. Note, only the rxs for the Current Location are pre-selected. Check or uncheck boxes in accordance with office policy prior to choosing **<Print>**. The printed Rx will match your state format. If not, contact customersupport@newcropRx.com. (Note: a fake signature is not affixed as this is illegal in many states.) Specify the number of **printed chart copies** if desired. (Transmitted prescriptions always have a single printable “receipt.”) Change the desired **Language** for patient education **Leaflets**. Some accounts will also print **Rx Support** (a one-page handout designed to encourage Rx filling.) Click **< Transmit>**, sending selected Rx to the next page where a pharmacy can be selected and leaflets and copies printed. (A displayed pharmacy can be pre-selected here and will appear on the Transmit Page.) . Upon arriving on the print page or upon transmission, the rx will have been added to the patient record, at the top of the Current Meds List. If an error has occurred, go to the Compose Rx page and move the rx to Previous Meds and rewrite. An explanatory note can be recorded in the Rx Detail.

Note: a set of insurance ID’s appear to the left on the prescription. This is a drug discount program, YourRx , provided at no cost for your patients. You need do nothing: it works automatically.

Transmit Page and Transmit Confirmation Page

Choosing the **<Transmit Rx>** option on the Route page, takes you here with the checked prescriptions. The patient’s previously selected pharmacies are at the top of the list, followed by an alphabetized location pharmacy list. (Pharmacies can also be assigned to a patient from Pt. Detail.) The patient’s insurance mail-order pharmacy may appear with a blue dot. Click the **Mail-order/Home Delivery** link if desired. Use the **<Add>** button to find a new pharmacy. Report incorrect or missing pharmacies. After transmitting, use your network printer for the receipt and **Patient Leaflet**. Note: There can be a few minutes before arrival when faxing, so please make patients aware of this, especially if the pharmacy

is within 5-10 minutes of your clinic. The **Pharmacy ID #** on the Rx may be used by a pharmacist to confirm the source of the rx.

Rx Detail, back on the Compose Page, Accessed via  adjacent to each rx, this page displays additional information. **Rx Processing Notes** allows attaching a message to the Rx and/or assigning it for review on the Status Page. **Patient Education** adds instructions that appear here and on the **Face Sheet**. After the rx is final and on the Current Med list, the Rx Detail page changes: An rx batch can be **RePrinted/Transmitted**, recording a duplicate transaction in the **Print/Transmit Log**. **Sig** changes are tracked and displayed.

Note the **Report Missing Rx** section above the pharmacy transmission log. If electronic “Success” is displayed, yet the pharmacy states they did not receive the Rx, please send us this information ASAP: it will be fully investigated. For a “missing” successfully faxed rx, contact the pharmacy directly and suggest they check their fax machine before they request renewals

Pharmacy Communication Pages: PharmCom

The **PharmCom** pages process renewal requests submitted electronically by pharmacies. **The pharmacy request cannot be modified. Only # of refills can be changed.** Some or all of the following steps may not occur, depending on the amount of information sent by the pharmacy.

From the **PharmCom Patient Select Page** EMR users must return to select the displayed patient before proceeding. Select the patient before denying or the Rx will not appear in the patient’s record. (*Direct users: if needed, correct name or spelling and re-search. If needed, [click here to add a patient](#)*) If the requested sig, tablet size or dispense # now differ from what the patient is taking, use **<Deny and ReWrite>** to generate a replacement Rx. (All PharmCom transactions, including denials, are displayed in the **Pharmacy Communications Log** on the Admin Page as well as the patient’s Current Meds or, if denied, in the **Cancelled /Denied Log** at the bottom of the Compose Rx page.

On the **PharmCom Drug Selection Page**, match the exact selected drug from the displayed choices. Deny or Accept and specify refills on the **PharmCom Review Page**

Admin Functions, **accessed via the NavBar or directly by Admin/Clerical**

Staff provides a variety of work-flow and processing tools.

Account Healthplan List: Build your list of insurance/formularies here. The list becomes a “pick-list” for each patient on the Pt. Detail page.

Maintain Pharmacies shows each location’s list of selected pharmacies. It can be built from here or allowed to accumulate as selected for each patient. Rarely used pharmacies can be deleted. Pre-assign on Pt. Detail.

Support Materials: Review or print out as desired. (You just did!!) Don’t forget the audio Tour if you want a quick overview: start on the Resource Page. *(Direct Users start on the Log-in Page.)* Use [Help](#) at the bottom of each page for more detail or use the support link.

The **Medication Entry and Refill Page**, also accessed by a link on the Compose Page, is used for 1) quickly recording medications for new patients or those prescribed by doctors outside your account. 2) entering and leaving as a Pending Rx for further processing by doctor or clinical staff.

Prescriber Report provides a log of all Rx authorized by a doctor. ***Pharmacy Communication Log*** provides a record of all electronic communications with pharmacies. *(Note that an Rx denied without a patient appears only here).*

(Direct Users: Add Patient is present if your account includes this function. A search to avoid duplicate entry occurs before adding a new patient.)

Welcome again...Be sure and send us your suggestions for improvements. That’s where we get some of our best ideas!!

Location and Resources Page

It's time to begin Electronic Prescribing!

By using this eRx system, you are taking the first step in enhancing your office's prescription handling. You will find this process to be both intuitive and easy to use. However, we strongly recommend a full orientation period prior to beginning. At a minimum you should review the "How to Write A Prescription" summary available on the Administrative Page or use the Tour link at the bottom of each page for an audio orientation. In order to help you navigate the system, each screen is described in great detail on the following pages. You will also find definitions for specific terms and fields that appear on the screens. We suggest that you review these pages prior to your eRx implementation. Each help page has a **summary** and **detail section**. If you need just a quick overview of the page, the summary section might be all you require. If you desire a more detailed explanation, continue on to the detail section.

Do these instructions apply to you?

This eRx software has several different features available. If your system does not have all available features installed, you will read about features that might not pertain to you. In most cases, links to these optional features will not appear on your screen. For example, our **Partner users**, who access this eRx system via one of our Partners, (EMR, PMS, etc.) may not need to login to the system and thus will not access a Login Page. Alternatively, our **Direct users** must log in directly to the eRx system and require a Login Page.

There are other instances where users will have different functionality. All of our eRx users have the basic features of our *Basic version* which allows electronic prescribing along with RxHub™ medication history, eligibility and formulary. Some users will have the *Comprehensive* option which includes patient-specific formulary information, drug/drug, allergy/drug and OTC/drug review along with patient leaflets. If you are using the *Basic* version only, the *Comprehensive* described in this document will not apply.

- Example1: Most of our Partner Users add new patients directly into their EMR or PM software. Therefore they will not see the Add New Patient function in their eRx.
- Example2: A Direct user chooses to use the *Basic version* and thus does not have drug-interaction information. Their screens will not display the link <Proceed to Review> for drug-interaction review.

If at any time if you wish to upgrade to another version, please contact your Account Manager.

Now it is time to provide you with some overall information:

General Tips That Might Help You

Connectivity. Our eRx system is Internet based. Therefore, in order to use our product you must be connected to the Internet. A high-speed connection (cable, DLS, etc) is necessary for efficient use. (Dial-up will work, but it is slow for regular use.) You will also need an Internet Web Browser installed on your computer. We recommend Internet Explorer version 6.0 or higher.

Maximize your work space. Be sure to click on the single square on the upper right corner of your browser screen. The larger the screen, the easier it will be to read. Another tip you might try is to push the F11 key. This will remove some of your browser tool bars and will allow you more space on your screen. Pushing the F11 key again will restore your tool bars.

If you have a choice of screen orientation, use the longer “portrait” view. If you are purchasing a flat panel display, look for one that rotates. You might also want to consider purchasing a tablet pc which allows you to travel around the office and still be connected to the Internet.

Saving information. Any information that you enter on the screen will not be updated or recorded until you save the information by clicking the appropriate button. The name of the button will vary from **<Proceed>** or **<Save>** etc, depending on the application. Clicking the appropriate button will then save your information. Alternatively, you may also use the tab key to move the cursor to any highlighted button and use the space bar to activate it.

Using the “back” button. Unlike “surfing” the Internet, the **<Back>** button will not take you to the previous screen. This is a safety measure: the “previous screen” may not show current patient information. Instead, if you

wish to revert back to a previous screen, use the navigation bar at the top of the screen or the buttons that say **<Return to Prior Page>**, **<Cancel>** etc.

Turn off Autocomplete. This browser feature displays previously entered information while you are typing. New Crop's search features work well with only the first 3 or 4 letters of a word, so Autocomplete is unnecessary and could be confusing. We suggest that you deactivate this feature by going to Internet Explorer and clicking Tools at the top. Then click **< Internet Options>**, **<Content>**, **<Personal Information>**, **<Autocomplete>**. Uncheck the box for "Forms."

Turn off the Google Auto-Fill Function. While this function allows automatic entry of your own name and address on web sites, it can cause text fields on your ERx pages to appear yellow. In order to avoid any confusion, we suggest that you disable this Google feature while using ERx. To disable this function, click on the button on the Google taskbar which says "### Blocked". You may restore the function after exiting ERx by clicking on the button which now states "pop-ups okay".

Help. ERx is designed to be simple and intuitive. In the event that you need it, there is a link to the Help Page at the bottom of each screen. You have two types of help screens to choose from. The [Popup Help](#) link displays the help screen in a separate screen for your review. Alternatively, you may choose the [Help](#) link which will add the help information to the bottom of the screen you are working on. After reviewing the help information, you may close the screen by clicking on **<Hide Help>**. We want to be sure you have all of the information you need, so if the help screen did not provide you with enough information, then click the adjacent Comments/Questions to send an email to Customer Support. We'll email you back.

Also, look for user tips to the right of the title bars. An example of the Patient Education title bar is below. Notice the *italicized* user tip located to the right.

Patient Education *Use Control key to multiselect, and add text as needed*

A complete listing of the Help pages is compiled in the Reference Manual, posted on the Admin Page. Orientation videos are also posted on the Admin

Page along with several screen shots. Use the [support@...](#) link at the bottom of the page for any remaining questions.

If you prefer an audio tour to reading, try the Tour starting on the Resource/Location Page before continuing on with this summary.

Read Me First Pages. A good way to begin is to review the “read me first” pages (How to Write a Prescription). These pages are “screen shots” and will show you the major components of each screen and how they are used. You can access the “read me first” pages by clicking on **<Administrative Functions>** on the navigation bar and looking under the section titled “Support”.

Practicing. Be sure to take the time to practice entering prescriptions before you “go live”. The easiest way to do that is to use the demonstration accounts that were preloaded on your system. The last names of the demonstration accounts all start with “zzz”. Take the time to enter information into these accounts to learn how each screen works. If you need further directions, remember to click the <Help> link at the bottom of each page.

ERx Basic and Comprehensive. Two versions of ERx are available which offer different features. The **Basic** version is our base version which has the drug list, indexed healthplans, indexed pharmacies, RxHub and SureScripts. The **Comprehensive** version adds automated allergy, drug and disease/condition review, herbals, and patient leaflets as well as managed care information which will identify which drugs reside on the patient’s insurance formulary.

Summary

The Location and Resources Page

This page is seen at the start of each day after logging in, or by clicking the Resources link on the top left side of the page below the Navigation Bar. Location / Workgroups reflects the workflow needed for prescription management within your practice. **NOTE:** for multiple Location/Workgroups, you will see all prescriptions written by all doctors within your practice from all locations. Be sure and follow your office policy as to when to process an Rx from another location or doctor. If locations are missing, contact your Account Manager.

Now that you are ready to e-prescribe you will begin on the Location and Resources Page. This page has several functions. You may use this page as a “quick” resource to find drug or formulary information. This page also displays Bulletin Board text. Additionally, this page allows the user to select the location where they will be working. Select your location or workgroup by clicking on it. If you do not see an approp

riate group or location, contact your account manager.

At all times, you will see prescriptions written by all doctors within your practice, regardless of location/workgroup.

Drug and Formulary Look-Up: The **Drug** function allows you quick access to drug information. Type at least the first 3 letters of the drug name, then click **<Look up a drug>** or use your Enter button. You will be directed to a screen which displays all drug names that fit your 3 letter criteria. The more letters you type in, the more specific your search results will be. Scroll down to find the appropriate drug. You will find the different dosage information following the drug name.

If you are using the *Comprehensive* option, clicking on [Monograph](#) displays the complete information on side effects, dosing, etc. in a popup window. Likewise, clicking on [Leaflet](#) displays patient educational materials for printing. Select the appropriate language. If the drug information is not available in the specified language, the default language will be English. To return to the Location and Resources Page, click **<Cancel/Close>**.

If you have the *Comprehensive* option, you are able to check the **Formulary** for a specific insurance plan. First select the desired insurance plan from the dropdown box. Next enter at least the first 3 letters of the drug name and click on the **<Look up a drug>** button. The popup screen will then indicate if this drug is “approved”, “non formulary”, “preferred”, “prior authorization required”, etc. for this insurance plan. To obtain further formulary information click on the coverage information link. (Example: If a drug displays a [Non Formulary](#) link, click on that link to find a drug which is covered. *This functionality is used as a general reference only. All patient-specific formulary information will be obtained from the Compose Rx Page.* Click **<Cancel/Close>** to return to the Location and Resource Page.

Account Manager's News displays any information that the account manager wishes to post and can function as a daily "blog." The information listed here can be only entered or deleted by the Account Manager.

Rx News and Announcements displays any information that ERx wants to share or convey to its users. New features and important updates are examples of the type of information you would find in this section.

Location / Workgroups *divide an Account into smaller units.* Your Account Manager has setup your Location/Workgroups to match the actual flow of prescriptions within your practice. A Location/Workgroup need not have a different address- you may have multiple workgroups or locations within a single office location.

- Example1: If you have several satellite offices, each satellite office might be considered a separate Location/Workgroup. Example:
Crestview OB/GYN has two satellite offices. Crestview West Side Clinic is one Location/Workgroup and Crestview East Side Clinic is the second Location/Workgroup.
- Example2: Similarly, you may have more than one workgroup within a single location. If Crestview OB/GYN has one large office, they might have two separate areas where physicians see patients. Each handles their own prescriptions. In this case, Crestview Area 1 would be one Location/Workgroup and the other would be Crestview Area 2.

Although a nurse and a doctor might be assigned to different Location/Workgroups within the practice, they will see the other's work at all times. A prescription written by any user, regardless of Location/Workgroup, will always be displayed in the patient record. It is important to follow your specific office policy as to whether you are authorized to process prescriptions written by users in your or other Location/Workgroups.

-

On this Location/Workgroup page, click on the name of the Location/Workgroup where you are working. Some users will have only one Location/Workgroup listed, while others may have several. If your list is incomplete or inaccurate, contact your

Account Manager. To return to this page at any time, you may click on [your Location/Workgroup name](#) in the upper left corner of your screen.

Your **last login** date and time can be found at the bottom of this screen. When you reach this page, you should verify that the date/time stamp is correct. If it is not, it may indicate unauthorized use of the system. Contact your Account Manager about any discrepancies.

The [Logout](#) link is located in the upper left corner of the screen. Click on this link when you are away from your computer for an extended period of time, or when you are done with your e-prescribing session. Logging out will deny unauthorized users access to the system.

</SPAN

The Select Patient/Staff Page

Navigation Bar

Summary

The NavBar at the top of each page provides a quick way to change tasks/pages. Note, your name, the current user on the left and the current **Designated Doctor/Prescriber**, whose name will go at the top of the prescription, to the right. (Make a change on the **Select Staff** (or Select Patient) Page. (A drop-down list for changing doctors also appears on the Compose Rx page.) **Pt Detail** displays the selected patient's address, insurance, etc and allows updating in some configurations. *An insurance plan must be entered for formulary coverage information to appear with drug selections.* Note Medicare Part D should go in the first slot. To the left, the [RxHub/RxHistory](#) may appear: click to view an all- doctor Rx history from the healthplan. **Pt Notes** enters information in the patient record. **Pt. Dx** displays the patient's and doctor's diagnosis list. **Admin** has reports and other supporting functions. (*Direct users only.* Select Staff is on the **Select Patient** page. Log out by clicking your name.) **Compose Rx** displays the patient record and is where a new Rx is written.

Before explaining the main sections of this page, it is important to describe the **Navigation Bar** that appears at the top of the page. The Navigation Bar is made up of a series of labeled buttons or "tabs" used to move from page to page within the website. The Navigation Bar is common to most pages. Some users, having different

responsibilities than others, might have different tabs on their Navigation Bar. In all cases, clicking on a tab will take you to the designated page. Use these tabs to navigate between pages. DO NOT use the <Back> or <Forward> keys.

The first tab, <Select Patient>, appears for **Direct Users only**. This tab allows the user to search for and select the correct patient. **Before Direct Users can enter patient information or compose a prescription, they must first select a patient.** (See Below for how to select a patient) **Partner Users** will see a tab which says <Select Staff> and allows the user to choose Staff.

The next tab, <Compose Rx> appears for any user whose category or role allows them to e-prescribe. (See the Status Page section below for further discussion of categories and roles.)

The <Pt. Details> tab is accessible to all users. Use this screen to add or edit patient demographics, insurance, contact information, etc.

The <Pt. Notes> section allows free-form notes for the patient to be entered. You may use this section to document course of treatment instructions, patient special requests etc. Previous or “Existing Note” will be displayed here.

The <Diagnoses> page allows the patient’s diagnoses to be searched and stored.

Finally, the <Administrative Functions> tab takes the user to a screen which allows reports and manuals to be printed, pharmacy information to be added, DOQ-IT information to be listed, etc. For more information on these pages, see the help screen for that particular page.

In addition to the tabs on the Navigation Bar there are links that navigate the user from screen to screen. These links, like the Navigation Bar, are available throughout the pages. In some cases, a doctor and/or patient must be selected before navigating to another page. In those instances, you will be prompted to enter the doctor and/or patient first.

<SPAN

style="FONT-FAMILY: Arial">

The following is an overview of these links:

Directly above the Navigation Bar, in the center of the page, is the **Status Bar**. The Status Bar is a link which reads **Pharm:** **Fax:** **Pend:** and indicates the number of Assigned Rx/Messages for this account requiring review. The numeral indicates the quantity of pharmacy requests, faxes needing attention and prescriptions pending review. This information helps the user keep current with the Account's workflow. By clicking on this link, the user is directed to the Status Page where these prescriptions may be reviewed and then redirected or acted upon.

Directly below the tabs on the Navigation Bar to the left of the screen is [Your Location/Workgroup Name](#). In some instances, the name may be abbreviated. Clicking on this link takes you back to the **Select Location** page where you may change your Location/Workgroup, logout, reset your password, review the bulletin boards, or use the quick drug reference tool.

Your [Login Name](#) followed by the word (logout) appears as a link to the right of your Location/Workgroup link. Click on this link to logout and complete your session, returning you to the Login page. It is a good habit to click on this link when you are going to be away from your computer for an extended period of time or when you are done with your e-prescribing session. Logging out will prevent unauthorized users from accessing the system. If you have two different logins you may use this link to toggle between the two (For example: You have one Login as Account Manager and a separate Login as Doctor/Prescriber) .

To the far right of the Login Name is the **Designated Doctor/Prescriber** (*person whose name will be listed at the top of the prescription*). The name listed here will appear at the top of any prescription written. The Designated Doctor/Prescriber can be changed on the Compose Rx page or Med Entry page by selecting the name from the Drop Down box on the each of those screens. Alternatively you may change the Designated Doctor/Prescriber from the Select Staff Page. (Select Patient Page for Direct Users) See information pertaining to the Select Patient/Staff below.

At times some or all of the following links will appear below the Navigation Bar depending upon the page you are viewing:

The <Progress Note> Link

This link appears on the Compose Rx page and provides a progress note to print and place in the patient's chart. This note lists the patient's known allergies as well as all current medications with the dosages and dates dispensed. Additionally, it affords the practitioner the ability to enter information such as height, weight, or chief complaint for this visit.

The < Face Sheet > allows you to display and optionally print a Face Sheet for the examining physician's reference. This Face Sheet displays the medications that the patient is currently taking as well as allergies, patient demographics and diagnoses in a printable format.

The <Pt. Face Sheet> is intended to be given to the patient. It is identical to the Face Sheet however all medical terminology is replaced with terminology that a patient will more easily understand. Medical terms such as "bid, tid, and sig" have been removed and replaced with common terms such as "twice a day" etc.

To print the Progress Note, Face Sheet and/or Patient Face Sheet, click your browser's Print button to send this form to the network printer.

The <Med Entry > Link

This link appears on the right side of the screen above the dropdown box containing the patient's insurance. Click on this link to go to the MedEntry/Refill page where you can enter previously prescribed medications into a patient's record without writing a prescription. You may also enter medications prescribed for the patient by another physician. A complete sig and dispense number are not required. Any prescription information entered here will appear in the patient's list of Current Medications. Additionally, prescriptions entered here can be entered into the queue for review and renewal.

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Similarly, for any med school students, the MedEntry page goes to the Review page and back. The med student can enter a patient's meds and can "try out" an Rx by looking for interactions etc, but the student is unable to send the Rx. A doctor then logs in and sends the Rx as appropriate. To set up med students, enter them in the

system as clerks just like you would enter any clerk user.

- Example1: A receptionist may enter medications into the patient's record that a doctor outside of this practice has previously prescribed.
- Example2: A receptionist takes a phone call from a patient asking that the Doctor/Prescriber renew a prescription. That information is entered into the queue from this screen and is available for review and processing by an authorized prescriber.

The **Patient's Name** and **DOB** (Date of Birth) are displayed on the left side of the page below the Navigation Bar. On some pages, the patient's insurance plan will be displayed on the right side of the screen. If the patient has more than one plan, the drop down box will permit you to scroll through the list of this patient's plans. You may use the drop down box to select the particular plan which applies to a prescription. (*Comprehensive* users only)

RxHub™ is an on-line managed care information source. If the patient is a designated RxHub™ patient, current eligibility will be displayed directly below the patient's name along with an [RxHistory/RxHub](#) link. Click the check box to view the patient's eligibility. Click the [Rx History/RxHub](#) link to view this patient's all-doctor prescription history as provided by the patient's healthplan. Confirmation of physician status and selection of a time span is needed first. If the patient is not an RxHub™ patient, these links will not appear.

Doctor / Mid-Level / Staff Selection

All users must ensure that a Designated Doctor/Prescriber's name is selected from the drop down box as a **Designated Doctor/Prescriber must always be selected before any prescription can be written**. Both are always selected on this page. Click on the dropdown box to make your selection if the displayed name is incorrect. The nurse or doctor you select will stay in place until changed by you. The doctor/prescriber can also be changed on the Compose Rx or Med Entry / Refill Pages. Physicians who log in will be unable to change the doctor's name. Similarly, staff members are unable to change the staff name. Return to this page to make a different selection as needed. Only doctors for this location are listed. Contact your account manager for missing names or incorrect information.

If you want more information, Doctor/Prescriber, Midlevel and Staff are further explained below:

The **Doctor/Prescriber** is authorized to submit prescriptions to a pharmacy under his/her own name. (Example: DDS, DO, MD, PA). They are the only individuals whose name may appear at the top of a prescription. This could be the name of a physician, but it could also be the name of a PA or NP, if allowed under your State statutes. When a user transmits a prescription, they must choose a Designated Doctor/Prescriber from this list.

The **Mid-Level Practitioner** (NP, APRN, PharmD, etc) is authorized to sign a prescription and submit prescriptions to a pharmacy under the supervision of a Doctor/Prescriber. The Mid-Level Practitioner user can write or renew prescriptions, although the Mid-Level Practitioner user cannot have their name listed at the top of a prescription.

The **Staff** Category is split into 3 roles.

- The **Clinical Staff** role, typically a nurse or medical assistant, may access the same pages and functions as Doctor/Prescribers and can call a prescription into the pharmacy however Clinical Staff cannot sign a prescription.
 - Example1: An office nurse receives a request from a patient to renew a prescription. The office nurse, in accordance with office policy, may then transmit the prescription with the Designated Doctor/Prescriber listed as authorizing physician.
 - Example2: A doctor asks his Medical Assistant to call an Rx in for a patient. The MA then enters the prescription into the system, listing the requesting physician as the Designated Doctor/Prescriber.
- **Clerical/Admin Staff** are not authorized to call a prescription to the pharmacy. However, within ERx, Clerical/Admin staff may enter renewal

requests into the queue for Doctor/Prescribers, Mid-Level users or Clinical Staff to review and/or authorize. Clerical/Admin Staff can also enter and edit patient's information as well as print Face Sheets.

- Example: A receptionist receives a phone call from a patient requesting a prescription renewal. In accordance with office policy, the receptionist may enter the renewal request into the queue for a Doctor/Prescriber, Mid-Level Practitioner or Clinical Staff to address via the Med Entry/Refill page.
- **Full Access Staff** are granted the same capabilities as the Account Manager. This allows more than one user to share password maintenance and other chores.

Patient Selection Only Direct users will have the ability to select a patient on this page. Partner users select their patients prior to entering the eRx program and thus will not see this section on their page.

It is important to avoid duplicate patients. For that reason you must first verify that the patient is not a current patient by using the Search function. On this page you will select a patient using one of several criteria:

To search by name, enter at least three letters of the last name. Entering a first name only will cause an error message to be displayed. Add a few letters of the first name in addition to the last name for common names (i.e. if searching Smith or Garcia, gives too many results.)

To search by number, enter at least 2 characters of the Medical Record Number (MRN), 3 digits of the Social Security Number (SSN with or without dashes), or 3 digits of the phone number (with or without dashes). Note: only the MRN requires exact entry of any dashes, spaces, etc. In the event that the patient you are seeking does not appear, try searching with a different identifier.

Once you have entered your search criteria, click **<Search>** to display the results. All matching names will be displayed as links. In many instances your search may result in more than one patient with the same name. You may verify your selection by noting the DOB (Date of Birth), SSN (Social Security number) and phone number that are displayed. If the desired patient is displayed, click on his/her name. In the event that the patient you are seeking does not appear, try searching with a different identifier such as SSN or MRN

If you are sure the patient is not already in the database and no patient is found matching the selection criteria, use the [Click here to add a patient](#) link that appears below the search results or go to the Admin Page and click on [Add/Maintain Patient](#).

You may also want to check with your account manager. Clicking the patient search button without entering any information will open the search box with the last 20 patients selected for this location.

When you have located the desired patient, click on the patient's name. You will then be taken to the **Compose Rx Page**. If this does not happen automatically, click **<Compose Rx>** on the Navigation Bar.

Patient Search Results: Displays the last twenty (20) patients selected for your location. If you do not see the patient you are looking for on this list, use the Patient Search to locate the patient.

Office Bulletin Board: The bulletin board may be used to informally display messages to all staff throughout the day. Type any message that you wish to send and click the **<Save>** button. To erase a message, highlight the text and choose the delete key on your keyboard. Click **<Save>**.

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The Status Page

Summary

The Status link, above the NavBar, takes you to the Status Page where all the prescriptions needing further processing are listed. Click the status link to go to the Status Page. **Pharmcom** = electronic pharmacy renewal requests. **Faxes Needing**

Attention = those that did not transmit correctly. **Failed Electronic Rx** will also be listed and require processing. **Pending** = Rx that have not been completely processed. Pending Rx can be one of 3 stages. **DR** has been assigned by staff for a *doctor* to review. **NS**, has been reviewed and approved by a doctor but still *needs staff* to send to a pharmacy. **InProc**, *incompletely processed*, has been assigned un-reviewed or left unfinished or forgotten by the displayed user.

Any prescriptions left on the Status Page at the end of the day represent “unfinished business”.

Note to Partner regarding access to a Patient: For some accounts, only the selected patient from the EMR [active patient on your side] is available for processing on the Status page. Users are unable to change patients on the Status page. The user must return to the Partner's application to select another patient and then return to the Status page to continue processing. Exceptions to this are re-faxing and NS status prescriptions; both of which are already part of Current Meds. *(Direct users are able to access and process all).*

The **Status Bar** appears at the top of all pages. The link displays 3 items. The first is **Pharm** or pharmacy. The number listed here is the number of pharmacy communications requiring attention for the entire Account. These are either refill requests or messages from SureScripts pharmacies. Clicking on **<Pharm>** will take you to the **Status page** where you can view the transactions.

The next link is **Fax**. The number after the word Fax is the number of faxes which were not successfully transmitted. Possible causes for their being on this list include wrong fax numbers or a malfunction at the pharmacy. Clicking on **<Fax>** takes you to the Status page where you can view the transactions. Once the fax has been successfully transmitted, it will be removed from this list.

The **Pending** link displays the number of incomplete or pending prescriptions for your Account. Clicking on **<Pending>** takes you to the **Status page** where you have the ability to view all transactions requiring your attention.

Although all transactions for your Account are listed on the Status Page, those which need attention from your Location/Workgroup are **bolded**. Any transaction listed here, however, can be accessed for pr

rocessing. Be sure to follow your office policy on handling prescriptions written in a different Location/Workgroup.

The **Status Page** is split into five sections:

(1) The **Pharmacy Renewal Requests** section lists all messages and refill requests received from the SureScripts pharmacies. The request lists the patient name, date of birth, date received, drug name, Doctor/Prescriber, Location/Workgroup and pharmacy. Clicking on the Patient Name takes you to the **PharmCom** page which displays the message in detail. From this screen you may deny the refill, or continue on to approve or respond to the pharmacy message.

(2) The **Failed Electronic New Prescription: Needs Reprocessing** section lists electronic prescriptions which were not successfully transmitted. The Patient Name, date the Rx was created, drug, Doctor/Prescriber and user are listed. You may click on the patient name to take you to the **RxDetail** screen where you will see the prescription details and can retransmit the prescription. This particular section title bar will not appear on the Status Page unless there are electronic prescriptions that have failed.

(3) The **Failed Fax Transmission: Needs Reprocessing** section lists any fax which was not successfully transmitted. Faxes listed in this section have not been transmitted. The Patient Name, date of fax, drug, Doctor/Prescriber and Location/Workgroup are listed. You may click on the patient name to take you to the **RxDetail** screen where you will see the prescription details as well as the transmission information. From the RxDetail screen you may reprint or retransmit the entire batch of prescriptions (if applicable) or just an individual Rx. If you are forwarding this prescription for another user's review, you may add an explanatory note at this time. Additionally, you may add patient education notes to the prescription which display on the Patient Face Sheet. To return to the Status Page, click on the [Close/Return to previous page](#) link.

(4) The **Staff Processing List** indicates prescriptions which are pending further review. Those prescriptions that are listed in bold type represent items that were entered at this Location/Workgroup. If a transaction is not listed in bold type (thus originating from another Location/Workgroup), it can still be processed if permitted

under your specific office policy.

Pending prescriptions can be of three types: NS, InProc or DR. **NS** (Needs Staffing attention) have been approved by the Doctor/Prescriber and are waiting further processing from Staff. If, for example, a Doctor/Prescriber approves a prescription and elects to wait and have his staff transmit it, it would be listed as **NS**. Selection of this patient listing will take the user to the **Route Page** for printing or transmitting to a pharmacy. **InProc** (in process) prescriptions are those which are left unfinished at any point in the Rx process. Selection of this transaction takes the user to the **Compose Page** for completion or deletions. **DR** (awaiting Doctor/Prescriber Review) indicates that a user has determined the prescription requires a Doctor/Prescriber's review.

(5) **The Doctor Review List** shows prescriptions that have been set aside by the Mid-Level, Staff or other Doctor/Prescribers for this Doctor/Prescriber's review as well as incomplete rx (InProc.). The prescriptions are designated **DR**. Prescriptions left incomplete after review by this Doctor/Prescriber will be returned to the patient's pending list and designated **InProc**. Selecting that Rx will take the user to the **Compose Rx Page**.

Note to Partner regarding access to a Patient: For some accounts, only the selected patient from the EMR [active patient on your side] is available for processing on the Status page. Users are unable to change patients on the Status page. The user must return to the Partner's application to select another patient and then return to the Status page to continue processing. Exceptions to this are re-faxing and NS status prescriptions; both of which are already part of Current Meds. (*Direct users are able to access and process all*).<

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The Compose Rx Page

Summary

Displaying the patient's **Current Medications** and any **Pending Prescriptions**, this page is the center of the prescribing process. Mid-page, note **Allergies** to drugs,

foods, etc. There is a **Memos** section as well as a drop-down that allows you to change the **Designated Doctor/Prescriber** which is handy for nurses processing multiple doctor's refills.

Start the prescribing process by looking up a drug. Type 3 or more letters and click **<Drug Search/List>** or use the Enter key. Select the desired formulation that then appears above as **Pending** where the sig can be added. To add the sig, click [Edit](#). Note the check box at the bottom of the Edit box. Checking this box adds the entire Rx to the **Doctor's Drug/Rx List** for future reuse. However, drugs are automatically added to the Doctor's List as they are selected. To view the Doctor's Drug list, leave the Search box blank and click **<Drug Search/List>**. Drugs can also be added or subtracted from lists by using the check boxes which appear to the right of each drug search result. Multiple **Current Medications** can also be selected for renewal by checking the boxes to the left of each current med that is listed. All newly selected drugs will appear at the top of the page as Pending Prescriptions. The **Instant Renewal** button in the Current Medications section of the page allows sending a batch of renewals directly to the patient's pharmacy.

Pending Prescriptions are part-way through the process but have not yet been added to the patient's Current Medication list. Any incomplete Rx are highlighted (for example, an incomplete or missing sig). In addition to those newly selected, you will also see 1) Rx left at any point in the process, Stage = **InProc**. 2) Rx left by Clinical Staff for doctor review = **DR**. An Rx that has been approved by the doctor, left for staff processing, but has not yet been printed or sent to a pharmacy is staged **NS** and is highlighted. You can click on the drug to change the strength or click on the formulary status to view the drug alternatives.

Rx may also appear in a box above the Pending section when information for full processing is not available. The drugs listed in this section are not used for drug review! Convert these to a Current Med by clicking and selecting from the search results.

To complete an Rx, click [Edit](#) if the Sig box is not already open. Select number, sig, and adjust the directions or pre-calculated 30-day supply as needed. Check PRN or DAW (*dispense as written*). Check **"90 days"** to generate a 3 month Rx in addition to the original Rx you are writing. Enter any **additional sig** such as insulin dosing for the Rx label. (Pharmacy data standards allow *only digits in the Disp# field*. Therefore, for dose-packs, tubes, insulin etc, click [Packaging](#) and select for the pharmacist. *Place the number of packages in the Dispense # field as the last step..*) Add any additional directions for the pharmacist. Open the **Diagnosis** list

and select for this Rx if desired. Save your changes by clicking **<Save>**. Change your mind for the sig by clicking **Undo**. Use the **X** to delete the entire Rx. Finally, click **<Proceed to Review>**. All Rx must be complete before proceeding.

The Dosing feature is accessed via the [Edit](#) option on the Compose Page. Once in edit view, you can access the dosing by clicking on the [dosing](#) link which displays below the drug name. Several indications will display. Select the desired indication and you will be presented with the dosing calculations based on the patient's age and weight. The dosing calculates for pediatrics so make sure to enter or adjust the weight as needed.

Current Medications can have multiple **Sources**. (1) prescriptions written by all doctors within your account are displayed with the Location. (Your current Location is bolded.) (2) medications entered by staff from the Med Entry page or (3) additional prescription records that may have been loaded from outside sources such as RxHub, RHIO, or IPA. Click [Edit](#) within the Current Meds to record a sig change. To discontinue a drug or eliminate duplicate records, use the check boxes and **<D/C>**. At the bottom of the page are links accessing additional lists: previously **Discontinued Medications**, **Prescriptions Cancelled** after leaving the Compose Page, and a log of the patient's **Pharmcom** activity, including denied renewals. The tan shading / tinting behind meds on the Current Meds list indicates that these medications are from an external source. Examples of external sources include meds imported from RxHub and meds entered on the MedEntry page that were prescribed by doctors outside of your account.

Additional features on the Compose Rx Page: Use the [MedEntry](#) link to (a) add a drug to Current Medications for a new patient or when prescribed by a doctor outside your practice (an External source), with any doctor's name/ start date or (b) leave an Rx for Clinical Staff or Doctors for later review and processing. To the left, the [Progress Note](#) and [Face Sheet](#) links each generate a Current Meds list in a printable format. **Patient Version** substitutes “

twice a day” for “bid” and displays Patient Education materials. (See Rx Detail, below) These features can also be accessed by clerical staff from the Admin Page.

The **Compose Rx Page** is the center of the eRx prescribing system, as each new prescription begins here.

Pending Prescriptions

Beginning at the top of the page, you will note all pending prescriptions for this patient. These prescriptions have not yet been added to the patient's Current Meds list and as indicated on the Status Page, each is coded with an **NS, DR, or InProc** (*denoting Needs Staffing, Doctor Review, or In Process, respectively*). These Rx's are not yet part of the permanent record but are included in drug interaction checking on the Review page.

If your Account has the Comprehensive functionality, you will see the Formulary status. You can click on the formulary status to display the drug alternatives. This is especially useful if the drug is non-formulary and you want to select a drug that is on formulary. You can also click on the drug name to change the strength if you need to do that. You will also see an [Edit](#) link associated with each pending prescription. Clicking on this link expands the fields to allow you to make changes to the prescription. A click on the **magnifying glass icon** takes you to the Rx Detail page which provides complete information on the prescription, including any additional directions, prescription batch and previous pharmacy transmission information. You also are able to add notes for both the patient and for other users to reference.

To delete a pending prescription, click on the **"X"** to the right of the prescription you want removed.

The **Dosing feature** is also accessed via the [Edit](#) link of Pending prescriptions. Once in edit view, you can access "dosing" by clicking on the [dosing](#) link which displays below the drug name. Several Diagnoses / indications will display. Select the desired indication and you will be presented with the dosing calculations based on the patient's age and weight.

- The dosing calculates for pediatrics so make sure to enter or adjust the weight as needed and click the <Update weight in Kilograms> button.
- If you want to calculate the dosing based upon a different frequency (ie, BID instead of Daily) select a different frequency from the drop down box.
- Similarly, if you decide you want a different strength (i.e., 500mg instead of 250 mg) than what you originally selected you can select the new strength from the box of that displays the various strengths.

Scrolling down will allow you to view the prescription that you are editing. You can make any changes as necessary and then click <Save> and you will be taken back to the Compose Rx page.

Drug Review

If your Account provides the functionality, you will notice a **<Proceed to Review>** button. This Drug Review process will notify you of any possible drug-drug, drug-allergy, or drug-OTC interactions. All new prescriptions will be added to the Pending

Rx section as InProc and will remain there until reviewed for interactions (if your account has that functionality) or printed/transmitted.

Adding a New Prescription

The area below Pending Rx labeled **Drug Search/List** is where you start to add a new prescription.

A new prescription can be generated several ways when it comes to finding and selecting the drug:

- (1) If the prescription is one that is commonly used by the Doctor/Prescriber, leave the search field empty and click on **<Drug Search/List>** first. This action brings up the Doctor/Prescriber's drug list which is automatically built by storing the names of the drugs the physician has prescribed. From here you may select the appropriate drug if it is displayed. To select a single drug, click on the drug name which appears in blue underlined font. To choose more than one drug, click the check box(es) to the left of the drug name.

Drugs are automatically added to the Doctor/Prescriber's favorites list when they are prescribed. To remove drugs from the Doctor/Prescriber's favorites list, click on the **<Drug Search/List>** icon to display the doctor's favorites list and then proceed to check the appropriate box(es) [to the right of the prescription line] of those drugs you would like removed from the doctor's favorites list and click **<Remove>**.

- (2) If a new prescription is not already on the Doctor/Prescribers Favorite List, type at least the first 3 characters of a brand or generic name into the search text box (You may also expand your search by clicking the **Include Obsolete Drugs** check box to add any withdrawn drugs to the list) and click **<Drug Search/ List>**. This action brings up the list of drugs that match your search query. The more letters you enter, the closer the search will be. With the drug's name you will find a description of the drug along with [Monograph](#) and [Leaflet](#) links. The Monograph link, when clicked, displays the drug Monograph on a separate page. Similarly, the Leaflet link displays the drug information in a format for patients. You are able to print a leaflet for the patient when you print/transmit the prescription.

- (3) Another way to start a prescription is to select a prescription from the patient's **Current** or **Previous** medications list. You can do this by clicking on the check box to the left of a **Current** or **Previous prescription**, and then click the **<Select>** button. This moves all checked drugs to the Pending Rx area along with the appropriate sig, dispense number and directions.

If your Account has Formulary functionality you will note that the patient's health plan formulary information is listed in the search results to the left of the drug name and dosage. NOTE: for formulary to work correctly, the patient's insurance must be displayed in the upper right corner of the screen below the Navigation Bar. If you have Formulary coverage and the appropriate health plan does not appear, either click the insurance dropdown list on this page to see if the patient has other insurances listed or go to the **Pt Details Page** and select the patient's insurance/formulary from the drop-down list. (Contact your account manager if your desired health plan is not listed). If there is no insurance displayed at all, you will need to go to the **Pt Details Page** to select it.

If the Formulary states **Not in Formulary** then the patient's insurer has not placed this drug on its Formulary. At this point, you may click the [Not in Formulary](#) link to bring up a new window which lists the equivalent drugs that are approved and should be considered instead. At your discretion, a drug that is listed as Not in Formulary may still be selected.

If an Rx is covered on the Formulary the [Covered](#) link will appear. Clicking this link provides the Preferred/Approved status. If **Generic Available** appears, click the ingredient name (displayed in parentheses to the left of the [Monograph](#) link) to display all formulations. If searched by ingredient and no generic is available, the brand name appears in parentheses.

When all drugs and proper dosages have been selected, regardless of which of the methods above you used to find the drug(s), click on the **<Select>** button to add the prescription to the pending Rx section.

From the Pending Rx section, enter the Sig and Dosage information from the drop down boxes. Click **PRN** (*as needed*) and **DAW** (*Dispense as written*) where applicable. The **Disp#** (*number dispensed*) will calculate and display a 30 day supply. You may overwrite that number at this time if you choose. Use the **Select Packaging** dropdown to display information on sizes of tubes, liquids, tablets

per bottle, etc.

NOTE: The *pharmacy data standards allow only digits in the Disp# field; therefore, for dose packs, tubes, insulin, etc., click packaging and select for the pharmacist, then place the number of packages in the Dispense # field as the last step.*

For purposes of CCHIT compliance, the ability to denote an Rx as Short Term or '**One Time**' has been added as a check box within the EDIT view of the Pending Medications and Current Medications. Checking this box causes "one time" to be displayed in the SIG display.

Selecting the **90 Day** box generates a 3 month Rx. Any additional information that you wish the patient to have on the label should be entered in the **Additional Sig** box. Any pertinent information for the Pharmacist should be entered in the **Pharmacist Message** box. You may also select a diagnosis from the patient's record in the **Select Diagnosis** box. Clicking **Add to Doctor's Drug/Rx List** incorporates this drug and dosage on the Doctor/Prescriber's Favorite list. When completed, click **<Save>** or click **<Undo>** to return and not save changes.

Note on Medical Rx Terminology

qd = daily

bid = twice a day

tid = three times a day

qid = four times a day

q4h, 6h, etc = every 4 hours, 6 hours, etc.

HS = bedtime

q a.m., p.m = daily in the morning, evening

qod = every other day

prn = as needed

DAW = dispense as written (do not substitute)

Imported Rx

If Rx are imported from another system they will be listed in their own imported Rx category. If they are imported without adequate information for full processing, they will be labeled: *Note, these Rx are not included in drug review.* To replace with an Rx on the Current Meds List, click the drug name and proceed. Delete the Imported Rx as desired. Some Imported Rx may have enough information to be included in drug interaction review and thus will not have the warning label. Any Rxs imported into Current Meds are considered to be from an External Source and will have a tan background. Examples of External Sources include meds imported from RxHub and meds entered on the **MedEntry** page that were written by doctors outside of the account.

Change Designated Doctor /Prescriber

To the right of the **Drug / Search List** is the **Change Designated Doctor / Prescriber** area which displays the selection box for the Doctor/Prescriber authorizing the Rx. Click to change if necessary.

Patient Allergies / Intolerances / Notes

Below the **Drug Search / List** box the allergy and the memo boxes are displayed. To add or delete allergies for this patient, click the **<Allergy / Intolerance Search>** button. The allergy / intolerance Search box will display with a blue border along with a list of common allergies / intolerances. At this time you can either search for new allergies to enter, delete previously entered information or search and click on **No known allergy** when appropriate.

Search for an allergy by entering all or part of a brand, ingredient, drug category or non drug item in the box and click **<Search for Allergy>**. The results display below the **<Search for Allergy>** button. Select the appropriate allergy by clicking on it. Use the "[click here](#) to add a non-drug allergy if not found" feature to add non-drug items. This feature allows you to type in the non drug allergy. After doing so, click the **<Add Non-Drug Allergy>** button.

Whether you added the allergy by sea

rching and selecting it or by typing it in as text, the next step is to indicate a severity or type in comments specific to this allergy. Use the **Select Severity** drop down box to assign a severity to the allergy. Severity is not a required step. If you do not know

the severity of the allergic reaction you are still able to enter comments into the text box that displays and then click **<Save Allergy>** or **<Save / Add Additional Allergy>** to add the allergy to the patient's list. Or, you can use the **<Close>** button to close out of the Allergy / Intolerance Search box.

The magnifying glass on the right hand side of the Allergy / Intolerance Search title bar allows you to view the **Allergy Maintenance Log**. This log displays the user, what they did (add, view, etc) with each allergy, the date the allergy was viewed, added or modified, the severity and any notes that were entered. To close out of the Maintenance Log, simply click the **<Close>** button located on the right hand side of the Allergy Maintenance Log title bar.

To delete an allergy that was previously entered, click on a specific allergy. This will open the **Allergy Detail** box which allows you to modify or delete the allergy. To delete it, simply click the **<Delete this Allergy>** button. Use the **<Save Allergy>** button after making changes or modifications to the severity and/or additional info. The deletions and modifications will appear in the Maintenance Log for future reference.

The allergy field is not required and can be updated at any time by returning to the **Compose Rx** page and entering the allergy information.

Current Medications

Current Medications prescribed or modified for this patient by all physicians on your account are listed below the Patient Allergies / Notes area at the bottom of the page. Each medication is listed along with the date, drug name, SIG, number dispensed (#), number of refills (Ref), Doctor/Prescriber's name and Location/Workgroup. (An asterisk (*) after the word SIG indicates there has been a change in the Sig).

Also available to the right of each prescription is an [Edit](#) link and a **magnifying glass** icon. Both of these features were described above in the Pending Rx section. The [Edit](#) button allows you to alter the Sig and Directions after a prescription has been added to the Current Medication list, if a patient has been instructed to take a medication differently than originally prescribed. After you have made the changes reflecting the new prescription instructions, click the **<Save>** button to save the Sig

modifications. Changes are recorded on the Detail RX along with the authorizing doctor and user. Remember, an altered sig displays an asterisk (*).

The **<D/C>** button is used to discontinue current medications. Discontinuing a current medication moves it to the **Previous Medications** list. To discontinue a current medication, select the check box to the right of the magnifying glass icon and then click the **<D/C>** button.

To renew one or more of the current medications click on the check box(es) to the left of each medication you want to renew. Then click the **<Select>** button. This moves all the selected prescriptions to the Pending Rx section for further processing / transmission.

The [Drug Review](#) link, when clicked, performs a drug review of all the patient's current medications.

The **<Instant Renewal>** button allows you to simply select all the drugs you wish to renew, select the appropriate pharmacy and click **<Instant Renewal>**. This process will send the selected prescriptions to the chosen pharmacy and move the original prescription to Previous Medications. (If no pharmacy is selected, or a prescription is incomplete, it will move to Pending Rx instead.) The selected prescriptions will then be listed at the top of the Current Medication list.

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Finally, at the bottom of this page are selection boxes to view additional rx flow detail. With all of the selection boxes, checking the box will display the items.

- (1) "Discontinued/ Previous Medications" When selected, all previously dispensed medications are displayed under the Current Medications list. By using the Previous Medications list the physician has the ability to review the patient's total prescription history.

The **<Move to Current Medications>** button which appears within the Previous Medications area allows you to move a medication to the Current Medication list by selecting the box to the right of the medication and clicking

the <Move to Current Medications> button.

- (2) "Cancelled Mid-Process" shows any medication that has been deleted with the X icon prior to being added to Current Meds.
- (3) "Pharmacy Communications" show all PharmCom / Surescripts transactions. Denials will only appear here and on the Pharmcom report on the Admin Page.
- (4) "Order Log" shows these manually written items that are not put on the Current Meds list. Ie. "wheelchair" When writing an "order," the user can choose to put the item in either location.
- (5) "Denied" shows these items only when an advanced feature, "Accept/Send" is in use. This feature allows, ie., a nurse to assign an rx to a doctor. This rx cannot be cancelled or deleted. It can only be denied.

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RxNorm

RxNorm is a drug index, an alternative to First Data Bank. If you are reading this via the link on the prescribing pages, your system is utilizing RxNorm. If you are reading it as part of the Reference Manual, it may not apply as many accounts do not utilize RxNorm. (To see which you have, look at the bottom of the Review Page.)

RxNorm was created by the National Library of Medicine. The goal was to supply a drug list meant for electronic prescribing that was available free-of-charge. Several high-quality drug lists already exist: First Data Bank, Multum, Gold Standard, etc. However, the licensing cost from each supplier was seen as an impediment to large-scale implementation of erx.

A second goal was to supply a cross-walk between all proprietary indexes: a “metathesaurus.” This would allow a patient’s drug history to be easily converted to alternate drug indexes, important for interoperability.

RxNorm does deliver these goals to varying degrees, however, it remains a work-in-progress as recognized flaws continue to be addressed. The primary problem is that the mapping from one index to another is not fully quality-controlled by RxNorm. Each provider of proprietary indexes supplies QA to varying extents. You are using a First Data Bank version, quality-controlled by NewCrop.

RxNorm is a drug index only. It does not have clinical content such as drug interactions and allergies. Within NewCrop, this content is supplied by First Data Bank. If you have a *Comprehensive* version of our software, you are seeing this.

A deficiency of RxNorm is that some drugs cannot be mapped to First Data Bank. **These are labeled “Unreviewed RxNorm.”** Since they cannot be reviewed for drug interactions or allergy, they appear in a so-labeled box on the Review page.

Drugs are unreviewable for several reasons. 1) They may be Canadian, and, thus, not part of First Data Bank. Only current FDA approved drugs are listed by FDB. For instance, Crestor is marketed in a 2.5 mg tablet in Canada only. 2) Compound drugs are not completely indexed. Thus, for instance, some oral contraceptives will be shown as Unindexed. 3) Over-the-Counter drugs are not always included in FDB, although most are. These, too, may appear as “unreviewed.”

As stated, RxNorm is a work in progress. We anticipate ongoing improvement and changes. Look for a category of “Canada Only” in the near future. Please send along your suggestions: customersupport@newcroprx.com

For more information, <http://www.nlm.nih.gov/research/umls/rxnorm/>

The Review Page

Summary

Interactions and allergies comparing the Pending Prescriptions to the patients Current Medications and each other, are displayed. If this is an RxHub patient, drug interactions are automatically checked against a 120 day all doctor history as well as Pending and Current Medications, [if your account has this feature](#). The **Drug/Condition check** is activated when the Dx or pregnancy indicator is passed from the EMR or PM system. (**Direct users:** enter a Pt Dx via the Nav Bar) Choose the next step from the buttons at the bottom to determine the fate of the selected Rx(s). Uncheck a box to split the batch as needed.

<Approve/Leave for Staff> allows doctors to add the batch to the staff list on the Status Page as an **NS**. Nurses may select **<Leave for Doctor Review>**, changing the selected Rx to **DR**, placing it on the Designated Doctor's review list on the Status Page.

If your Account has the functionality, the top of the **Review Page** displays **drug-drug**, **drug-allergy** and **drug/condition** interactions and additional alerts. The rx is checked against Current and Pending meds. If the patient is an RxHub patient, **drug interactions** are automatically checked against a 120 day all-doctor history as well as Pending and Current Medications. **Contraindicated** appears in **red** and indicates a predictably severe consequence of concurrent use of two drugs. **Severe** appears in **yellow** and indicates action may be required to reduce the risk of adverse reaction. **Moderate** appears in **yellow** and generally indicates a need to adjust medications. **Herbal** interactions are not characterized as to severity due to lack of standardized content and dosage. Use the [More Info](#) link to see complete information on any potential interaction listed.

Allergy compares the rx to the patient allergies as entered on the Compose page are passed from an EMR. Detail is not available as it relates to the individual patient response.

The **Drug/Condition** check is activated when the Diagnosis (ICD) or pregnancy (V code) is passed from the EMR or PM system. (**Direct users:** you can enter the Pt Dx via the Diagnosis tab on the Nav Bar). Detail is not available as it relates to the individual patient response.

Pending Prescriptions from all workgroups in your account are displayed. You may deselect a prescription to transmit it individually. All selected prescriptions will be transmitted as a batch.

Clicking **<Proceed to Print/Transmit>** takes the current batch to the Routing Page where it will then be transmitted.

If neither printing nor transm

itting is needed, (such as for a Schedule 2 drug) click **<Finish/Add to Current Meds>**. This adds the Rx to the patient's Current Medications but does not allow any further transmission of the Rx.

Doctors who choose to have their staff finish transmissions may click the **<Approve/Leave for Staff>** button. This transfers the Rx to the doctor's assigned nurse, marks the prescription with an **NS** status, and places it in the Staff Processing List on the Status Page for further processing.

If the user logged in is not a doctor and proceeds to the Review Page, the above described **<Approve / Leave for Staff>** button will be replaced with a **<Leave for Doctor Review>** button. This transfers the prescription to a Doctor/Prescriber, marks it with a status of **DR** and places it in the Doctor Review List on the Status Page for further processing.

Clicking **<Return/Additional Rx>** returns you to the Compose Rx Page where you may add another prescription.



You may delete a prescription at this point in the process by clicking on the "X".

Note the select check boxes to the left of each pending Rx on the Review Page. If left **unchecked**, no action will be taken on this Rx at this time.

Below the Rx on the page are **<Print/Add to Current Meds>** and **<Transmit>** buttons. If you desire to skip the **Route** page you can use these buttons to add the prescriptions to **Current Meds** and print them locally or go directly to the **Transmit** page by clicking the **<Transmit>** button.

The Batch Concept

Note the check boxes to the left of the meds being processed. On this and subsequent pages, un-checking a box splits the batch for separate processing. For instance, a Schedule 2 drug must be printed, while the rest of the batch can be

transmitted to the pharmacy.

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The Routing Page

Summary

A batch of prescriptions ready for printing or transmission is displayed. Note, only the Rx's for the Current Location are pre-selected. Check or uncheck boxes in accordance with office policy prior to choosing <Print> or <Transmit>. Specify the number of **printed chart copies** if desired. (Transmitted prescriptions always have a single printable "receipt.") Check the box(s) for a **printable patient leaflet** as needed. (Select or change the **patient language first**.) If you would like each Rx printed on a separate page, check the **Print Singles** box. Click < **Transmit**> to send all selected Rx to the next page where a pharmacy can be selected and leaflets and copies printed. (A displayed pharmacy can be pre-selected here and will appear on the Transmit Page.) The printed Rx should match your state format. If not, contact customersupport@newcroprx.com.

The **RX Support** feature (not always present) provides printable information designed to encourage the patient to fill the Rx as written. This information will print out with the Rx or Transmit receipt unless you uncheck the Rx Support box.

Upon arriving on the print page or upon transmission, the Rx will have been added to the patient record, at the top of the Current Meds List. If an error has occurred, go to the Compose Rx page and move the Rx to Previous Meds or Edit to modify an incorrect sig. An explanatory note can be recorded in the Rx Detail.

You will find yourself on the Route page after having clicked **<Proceed to Print/Transmit>** on the Review page. All prescriptions will be displayed on the Route Page but only the Rx for the Current Location are pre-selected. You may make changes by unchecking a box. For example, if you want to print 2 prescriptions and transmit the other 3 you would uncheck/select the two you want to print.

The first option on this page allows you to choose the **number of chart copies** of this prescription that you wish printed on paper. By clicking on the **Number of copies** drop down box, you may choose from 0 to 3 copies to print. The default setting is zero printed copies. If the prescription was transmitted electronically, you will have the option of reviewing a printable proof of transmission when you reach the Transmit Page. The copies on this page are in addition to the one printable from the Transmit Page.

If you want a Patient Leaflet to print, select a **patient language**. If the patient's language was entered on the Patient Details page that will be the default language that appears here. If not, select the appropriate language and check the box(s)

for a **printable patient leaflet** as needed. These boxes appear to the right of each prescription, allowing you to select which leaflets to print if you do not want a leaflet printed for each prescription (This is a Comprehensive account option only). A record of the leaflet selection is added to the Rx Detail. If the requested language is not available, the leaflet will print in English.

Prescriptions will print up to 4 to a page or as required by your state. The **Print as Singles** option allows you to print each prescription on a separate page if you have multiple prescriptions being transmitted and you want each printed on a separate sheet of paper.

RxSupport

This feature (although not always present) provides printable information designed to encourage the patient to fill the rx as written. These will print out with the Rx or Transmit receipt unless the box is unchecked. If the Rx Support information is available for the medication being prescribed, the Rx Support box will be checked. If the box is not checked, then there is no Rx Support information available.

Schedule 2's

Note the **Drug Schedule (Sch*)** column to the right of the prescription selection boxes. Schedule 2's, such as Percodan, must be individually signed by the physician on state-mandated paper forms and cannot be transmitted. ERx can support specialized printer set-up if needed. Contact customersupport@newcroprx.com to set up your state's format.

How can you add Schedule 2 drugs to the patient record? You can use the **<Finish/Add to Current Medications>** option on the previous page (Review Page). Alternatively you can add them to the record from this Route Page, by clicking **<Print/Rx/Add to Current Meds>**. By **not** clicking on the [Print Prescription](#) link on the next (Print Rx) page, you will not print the Rx on paper. You can then handwrite the Schedule 2's.

Pharmacy

If an Rx is a refill and was previously sent to a pharmacy, the pharmacy name, address & phone number will be displayed to the left of the prescription. If the Rx has no pharmacy name in this box, you will choose a pharmacy on the Transmit Page.

Coming Soon: A **<Send>** next to each pharmacy that will transmit the prescription immediately, bypassing the Transmit Page. No leaflet or receipt will be generated

Routing Prescriptions

You have two options on this page for routing prescriptions. (1) For those prescriptions you do not wish to transmit electronically or via fax to the pharmacy, use the **<PrintRx/Add to Current Meds>** button. Doing so automatically adds the selected prescriptions to the patient record and takes you to a print page where each prescription will be displayed along with any requested leaflets and additional copies. NOTE: In the event an error has occurred, the RX cannot simply be deleted at this point. You need to go to the Compose Rx page and move the incorrect Rx to **Previous Meds** -- OR -- use the **Modify Sig** feature ([Edit](#)) where you can record an explanatory note in the Detail Rx if desired.

If you want to print the prescriptions, leaflets and copies, click on the [Print Prescription](#) link that appears above the prescriptions to access your network printer.

If there are any remaining prescriptions for the patient, you will see a [Return to Routing](#) link adjacent to the Print Prescription that will display the number of prescriptions remaining on the Route Page. Clicking this link takes you back to the Route Page where you can continue processing the other prescriptions.

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(2) Your second option for routing prescriptions is to use the **<Transmit RX>** button. Clicking

this button will send all selected prescriptions to the next page where a pharmacy can be selected and leaflets and copies printed.

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The Transmit Page and Transmit Confirmation Page

Summary

Choosing the **<Transmit RX>** option on the Route page, takes you here with the selected prescriptions.

You can send prescriptions as mail order by clicking on the [mail order / home delivery](#) link, verifying the shipping address and selecting the pharmacy.

The patient's previously selected pharmacies are at the top of the list, followed by an alphabetized location pharmacy list. The patient's available mail order pharmacies are denoted with a blue dot. Add to the displayed pharmacy list from the link at the bottom of the page. Report incorrect or missing pharmacies so we can correct the selection list. After transmitting, use your network printer for the receipt and **Patient Leaflet**. **Note:** There is a slight delay with transmitting, so please make patients aware of this, especially if the pharmacy they are going to is within 5-10 minutes of your clinic.

The **Pharmacy ID#** located next to the DEA on a prescription is a unique identifier that may be requested by a pharmacist to confirm the source of the Rx.

The **Transmit page** is the last page in the prescribing process. You reached this page by selecting **<Transmit RX>** from the Route Page for electronic (or fax) processing. On the top of the page, the prescription(s) you have selected is listed.

Each faxed prescription is accompanied by a message to the pharmacist, explaining the nature of the electronic Rx system along with the office contact information.

If a pharmacy name was pre-selected on the Routing Page, the pharmacy name and fax number will already appear. If no pharmacy was pre-selected you must now choose one from the list. The patient's previously selected pharmacy is denoted at the top of the list with a **black dot** to the left of the pharmacy name. Those pharmacies without the black dot are also used by this patient but not as recently.

Mail Order

If you desire to send the prescriptions as mail order, there is a [mail order/home delivery](#) link on the transmit page directly beneath the prescriptions. Clicking on

this link will open up the shipping/mailing address of the patient. Verify the address by checking the box. If the patient's mailing address is not populated, fill in the information. It will be saved in the patient detail for future mail order requests.

NOTE: all prescriptions listed on the transmit page will be submitted as mail order prescriptions when the [mail order /home delivery](#) link is clicked.

After verifying the patient's mailing address, select the pharmacy as you normally would and click the **<Transmit RX>** button.

Selecting a Pharmacy

A **blue dot** in the eRx column indicates that this patient utilizes an electronic mail order pharmacy. In this case, the Mailing address is displayed and is required for all mail order pharmacies.

A **green dot** under the eRx column indicates that this pharmacy is a participant in our **electronic pharmacy network**. In other words, pharmacies listed with the green dot can accept prescriptions electronically. If there is not a green dot in the eRx column then the prescription will be automatically faxed to the pharmacy. All pharmacies listed can accept prescriptions by fax provided the fax number is listed or you input the fax number prior to transmission.

However, there are a few instances when a participating pharmacy cannot accept a prescription electronically.

1) If there is a Schedule 2 or other non-compliant drug in the batch, or

2) A doctor has not yet been approved by the network, or

3) A connection to the electronic network is not possible.

In either of these cases the pharmacy will require a fax. You must be sure that a fax number is provided. Verify that the correct fax number is listed for the chosen pharmacy.

If the fax number is incorrect or is not listed, enter the fax number in the field labeled **Via Fax:** Corrected numbers are stored and displayed for future use.

If your pharmacy is not on the list, there is an [Add a pharmacy to the list above](#) link located at the bottom of the page that opens a Pharmacy Search box where you can search for the desired pharmacy by entering 1 or more fields. Zip codes alone generally work well. Once you have entered your search criteria, click **<Search>**. The search results will display below. Select the pharmacy by clicking on the pharmacy name. This results in the selected pharmacy being added to the patient's list of pharmacies as well as your Location/Workgroup's list of pharmacies.

If the pharmacy you are searching for is missing from the list, or if any displayed information is incorrect, please click on the [missing/incorrect pharmacies: inform Support Services](#) email link at the bottom of the page to inform us so that we may correct the database.

Finally, when you have the correct pharmacy selected, click the **<Transmit Rx/Add to Record>** button, sending the Rx and adding the new information to the patient's record. **Once the prescription has been transmitted, these prescriptions can no longer be cancelled or modified.** If an error has occurred, go to the Compose Rx page and move the incorrect Rx to **Previous Meds** -- OR -- use the **Modify Sig** feature ([Edit](#)) where you can record an explanatory note in the Detail Rx if desired.

Clicking the **<Transmit Rx/Add to Record>** button takes you to the **Transmit Confirmation Page**. You will see a printable

220;receipt” of the completed transaction along with any additional selected copies or leaflets. Use the Print link to access your network printer. Note the adjacent [Return to Routing](#) link that displays any remaining prescriptions for this patient on the Routing Page.

Note: the **Pharmacy ID #** listed to the right of the DEA number is a unique identifier that may be requested by a pharmacist to confirm the source of the Rx.

If there are no prescriptions left on the Route page, use the tabs on the Navigation Bar to select your next task.

Note: There is a sight delay with transmitting, so please make patients aware of this, especially if the pharmacy they are going to is within 5-10 minutes of your clinic.

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Pharmacy Communication Processing Pages: (PharmCom)

Summary

The **PharmCom** pages process renewal requests submitted electronically by pharmacies, using a Federally-mandated sequence: ***the pharmacy request cannot be modified. Only # of refills can be changed. If the pharmacy is not correct, you must deny the prescription.*** Some or all of the following steps may not occur, depending on the amount of information sent by the pharmacy.

On the **PharmCom Patient Select Page**, select from the displayed search results. If the patient is not seen, correct the name or spelling and re-search if needed. Select the patient before denying or the Rx will not appear in the patient's record. Direct Users can add a new patient by clicking the [click here to add a patient](#) link. Again, ***the Rx cannot be modified***, so, if the sig, tablet size or dispense # has changed, use **<Deny and ReWrite>** to generate a replacement Rx. (All PharmCom transactions, including denials, are displayed in the **Pharmacy Communications Log** on the Admin Page as well as the patient's Current Meds or, if denied, in the **Cancelled Denied Log** at the bottom of the Compose Rx page. **Scheduled drugs**

cannot be sent via Pharmcom so they will follow a different outgoing path. They cannot be sent electronically, but, in many states, can be faxed. Thus, when responding to the renewal, you will see the Route Page where you can make your choice. The sending pharmacy is displayed on the Transmit page.

On the **PharmCom Drug Selection Page**, match the exact selected drug from the displayed choices. Make your final decision on the **PharmCom Review Page**. The sig, as sent by the pharmacy cannot be changed.

You may use this page to process renewal requests and other messages submitted by pharmacies via the SureScripts and other electronic networks. The number of pending pharmacy communications is displayed on the **Status Bar** at the top of all pages. Click the bar to view the Status Page and the patient list. Depending upon the amount of detail the pharmacy sends with the renewal request, there may be certain steps that can be omitted from this process such as the PharmCom Patient Select page and the PharmCom Drug Selection page.

Begin by selecting a patient under the **Pharmacy Renewal Requests** heading located on the Status Page. The Status Page can be reached by choosing the [<Pharm:x Fax: x Pend: x>](#) link at the top of each page. Once you have selected a patient from the list you will be taken to the **PharmCom Patient Select Page**. Select the correct patient from the displayed search results.

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If the patient is not found, be sure the pharmacy has not misspelled or used a different name from what your account uses (i.e. Larry vs. Lawrence). Use date of birth to confirm identity. Perform another search using fewer letters or last name only. If, after trying all alternatives, you believe that the patient is truly not there

Direct Users: , add the patient to your account by clicking the [click here to add a patient](#) link. Once you have completed entering the necessary information to add the patient, return to process the pharmacy message.

EMR users: return to add the patient there.

You may deny a prescription at this point. Use the drop down box to select a reason for the denial. If none of the reasons are applicable, you may type in your reason for denial in the box provided. Click **<Deny>**. A notification of denial will be transmitted to the appropriate pharmacy, and you will be shown a confirmation to that effect. If a

message is left in mid-sequence, it will be returned to the Status Page list for processing at a later time. **Scheduled drugs cannot be sent via Pharmcom so they will follow a different outgoing path. They cannot be sent electronically, but, in many states, can be faxed.** Thus, when responding to the renewal, you will see the Route Page where you can make your choice. The sending pharmacy is displayed on the Transmit *If a patient is not selected before denial, the record will appear only on the Pharmcom Log on the Admin Page.*

SureScripts and the participating pharmacies have required specific data standards that limit doctor choices: **the medication, dispense number, and sig cannot be modified.** If any of the above are incorrect, the prescription must be Denied and, a new prescription must then be sent. A message to that effect is one of the choices in the Deny drop-down reason's list (denied, new prescription to follow).

All PharmCom transactions are recorded and displayed in the **Pharmacy Communications Log** which can be accessed from the Admin Page. PharmCom transactions can also be viewed from the **Compose Rx page** by checking the **Show Patient PharmCom Log** box to view the accepted PharmCom transactions or by checking the **Show Cancelled Medications** box to view denied PharmCom transactions. If desired, these can be highlighted and printed.

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PharmCom Drug Selection Page

Upon patient selection, you will be on the **PharmCom Drug Selection Page**. The drug that is being requested by the pharmacy is highlighted in green. A list of matching drugs is displayed below that area. From the Search Results, match the exact drug by clicking on the requested drug, formulation or tablet size (i.e., [Prozac 10 mg Cap](#)).

The sig as sent by the pharmacy is "text" that cannot be entered for dose checking or easy refills. Therefore, it is recommended that you [Edit](#) the Rx to enter the sig as written by the pharmacy and delete the unneeded pharmacy text sig before accepting the prescription. For example, the pharmacy request sig reads "take one capsule twice a day". You would edit the sig and (a) enter "1", (b) confirm the type is "capsule", (c) enter "BID, (d) delete the "take one capsule twice a day" text that is in the "additional sig" box, and (e) click **<Save>**.

Remember: The sig and dispense number from the pharmacy have already been entered and cannot be changed. If you need to modify the medication, dispense number or sig, the prescription must be denied. Thus, a message to that effect is listed as one of the choices in the Deny drop-down reason list (Denied, new prescription to follow). . **Scheduled drugs cannot be sent via Pharmcom so they will follow a different outgoing path. They cannot be sent electronically, but, in many states, can be faxed.** Thus, when responding to the renewal, you will see the Route Page where you can make your choice. The sending pharmacy is displayed on the Transmit page.

Once you have selected the correct “match” you will be taken to the **PharmCom Review** Page where you will make your final decision.

PharmCom Review Page

After you have selected the appropriate drug and formulation, you are taken to the **PharmCom Review Page**. Here you will see the patient’s pending prescriptions along with any allergies and drug interactions if your account has Comprehensive features. The patient’s list of current medications is also displayed. If there is a prescription pending that is a duplicate of the Pharmacy request you received, you can click on the “X” that is located to the far right of that pending prescription to remove it from the pending list and add it to the patient’s cancelled/denied list. This helps avoid generating duplicate prescriptions.

Scheduled drugs will follow a different outgoing path. They cannot be sent electronically, but, in many states, can be faxed. Thus, when responding to the renewal, you will see the Route page where you can make your choice to transmit (via fax) or print. If proceeding to transmit, the sending pharmacy is displayed on the Transmit page.

After doing so, confirm that the requested drug and the drug you selected match. If not, use the **<Return to Correct Errors>** button to start over. Otherwise, if applicable, enter the number of authorized refills and click **<Accept>**. The medication has been added to the patient's current medication list and a record of the request has been recorded in the **Pharmacy Communications Log** which is accessible from the Admin page or from the Compose Rx page by checking the **Show Patient PharmCom** box.

You will also note that the PharmCom Review page, like the PharmCom Compose page, provides you with the **<Deny and Rewrite>** option as well as the **<Deny>** option in the event you find yourself on this page and realize you are unable to accept the request as submitted by the pharmacy for this patient.

Once you have replied to the request you will view a **PharmCom Confirmation** page. From here, use the tabs on the Navigation Bar to take you to your next activity/task.

End of REFERENCE MANUAL

The Rx Detail Page

Summary

Accessed via the magnifier icon adjacent to each Rx, this page displays additional information regarding the Rx. (Coming soon: as the Rx is being processed, **Pre-Select Pharmacy** allows instant sending of the Rx upon doctor approval or for later use by the nurse). The **Email** function will send a copy of the Rx as appropriate. **Rx Processing Notes** allows attaching a message to the Rx and/or assigning it for review on the Status Page. **Patient Education** adds instructions that appear here and on the **Patient Face Sheet**. After the Rx is final and on the Current Med list, the Rx Detail page changes: An Rx batch can be **RePrinted/Transmitted**, recording a duplicate transaction in the **Print/Transmit Log**. **Sig** changes are tracked and displayed. **Pt. Notes** about the Rx, such as side effects can be recorded.

Note the **Report Missing Rx** section above the pharmacy transmission log. If electronic "Success" is displayed, yet the pharmacy states they did not receive the Rx, please send us this information *ASAP: it will be fully investigated*. For "missing" successfully faxed Rxs, contact the pharmacy directly and suggest they check their

fax machine before requesting renewals.

Rx Detail displays the complete information about the Rx for your review. This page displays different information before the prescription is transmitted (Pending Rx) and after transmission (Current Med). In each case, you reach this page by clicking the **magnifying glass icon** on the prescription line. To obtain specific information concerning the medication, click the [Monograph](#) or [Leaflet](#) links located on the **Rx Detail** page.

Viewing Detail Prior to Transmission (Pending Rx)

At the top of the Rx Detail page, the Sig information is presented. The Sig information is meant for review only. To change any Sig information listed on this page, return to the previous page and click on the [Edit](#) link. To obtain specific information concerning the medication, click on [Monograph](#). To review the information that will print on the patient's leaflet regarding this medication, click on [Leaflet](#).

Select Pharmacy for Auto-send with Approval (coming soon) As the Rx is being processed, the user can pre-select the pharmacy for instant sending of the Rx upon doctor approval or for later use by the nurse. Entering a pharmacy here allows the Doctor/Prescriber (or other authorized prescriber) to bypass having to select a pharmacy at authorization time thereby saving him/her some processing time. The pharmacy selected here automatically receives this prescription once it is authorized and transmitted.

Viewing Detail of a Current Medication

Once the prescription has been reviewed and transmitted, it becomes part of the patient's permanent file and is listed as a Current Medication on the Compose Rx page. If you click the **magnifying glass**

icon on a Current Medication, you will see different features have been added to this screen. Below the Original Rx section the prescription is listed along with any other prescriptions that were transmitted or printed at the same time.

Emailed Copy of Rx allows notification to be emailed to the patient or any other authorized party, that this particular prescription has been transmitted to their selected pharmacy.

Rx Processing Notes records information about the prescription. This information is not transmitted to the pharmacy, but is used for internal messaging/documentation only.

Any text written in the **Patient Education** box or chosen from the drop down box below will display on the Detail Page as well as the Patient Face Sheet.

At any time during the review of this page, clicking on **<Close/Return to Prior Page>** takes you back to your page of origin. Any changes will be saved only if the **<Save/Send>** button is clicked.

The **Print Transmission Log** is also displayed on the **Detail Rx** page. If the prescription was transmitted electronically you will see the details of that transmission. A successful transmission will display the word "Success". Occasionally a pharmacy will report that they did not receive an electronically transmitted prescription even though the log states "success". If this occurs, please click the **<Report Missing Rx>** button immediately upon hearing from the pharmacy or patient. This will allow us to verify that the transmission was indeed complete. This feature is only to be used for prescriptions sent electronically. For "missing" successfully faxed Rxs, contact the pharmacy directly and suggest they check their fax machine before requesting renewals.

Clicking on the **<Reprint/Transmit>** button provides you the ability to retransmit or reprint the prescription. If the prescription was part of a batch you have the option of retransmitting or reprinting the entire batch or an individual prescription. Any retransmissions or reprinting will be documented in the **Print/Transmit Log**. You may use this feature when you need to resubmit a prescription or an entire batch of prescriptions.

Sig History displays a log of all sig changes made to this prescription.

The authorizing doctor and user are both displayed. The sig changes will be listed on the patient record.

Patient Note Entry allows you to document any notes regarding the prescription such as side effects. Remember to click the **<Save Note>** button after you have typed in your patient note.

Patient Education adds instructions that appear here and on the Patient Face Sheet. As with the Patient Note Entry, remember to click the **<Save Note>** button to retain any information you typed in this area.

At any time while viewing this Detail Rx page, you can click on [Close/ Return to previous page](#) to go back to your page of origin. Remember, changes will be saved only if the **<Save Note >** button is clicked prior to exiting the page.

Administrative Page Functions

The Admin Page lists a variety of functions designed to make your office run more efficiently that don't necessarily fit directly into writing a prescription. Come here to print reports or forms, build lists, add patients, and review our supporting materials.

Clinical staff can enter the Admin Page by selecting the **<Admin>** tab on the far right of the Navigation Bar. Clerical/Admin staff come directly here.

Select a task on the Admin Page and click on the Help link at the bottom of each page to learn more. This entire reference manual can be viewed and printed from the [Reference Manual](#) link on the Admin Page.

[Add Patient](#) is present if your account includes this function. Note that a search for duplicates is required prior to adding a new patient

Coming soon...

- (1) **Medicare PartD-O-Lizer** displays choices available to the patient and a summary of drug coverage.

click on the [click here to add a new patient](#) link. Fill in, at a minimum, the required fields marked with an asterisk (*).

Don't forget Gender and Zip code. These are needed to access RXHUB: formulary, eligibility and patient Rx history.

The following data formats are used. The medical record number should always be entered exactly in your format, including any dashes or other characters.

type

&

nbs;	Valid format
Dates	Month/Day/Year or MMDDYYYY Example: 3/20/2004, 0320
Phone Number	(NNN) NNN-NNNN or NNN-NNN-NNNN or NNNNNNNNNN
Zip Code	Five numbers
Zip4	Four numbers
SSN	Nine numbers or NNN-NN-NNNN

To change information for a current patient, click the <Pt Details> tab on the Navigation Bar. Make the desired changes and click <Save>.

Note the check box labeled Current at the top of the page. If unchecked, the patient will not appear for prescription writing. Uncheck the box for those patients that have moved away, etc. They can be made Current again at any time by coming back to the Pt. Details page and checking the box.

Pharmacy Communication Log

Summary

The **Pharmacy Communication Log** provides a record of all electronic communications with pharmacies via the Surescripts network. Use your mouse to highlight and print reports if so desired. (Note that an Rx denied without a patient appears only here).

This Log provides you a way to view a record of prescriptions that have been received from pharmacies electronically and then processed back through to pharmacies. If a prescription is denied, particularly for an incorrect patient, a record of the transaction will only appear here. (Approved prescriptions are added to the patient Current Medication List.)

Click the [Pharmacy Communications Log](#) link from the Administrative Functions page to see the log of transactions. To print: 1) Use the mouse to select the desired content. 2) Click <File> on the browser navigation bar and select <Print>. 3) Select a printer and click the "Selection" option in the Page Range Box. 4) Click the <Print> button.

Prescriber Report

Summary

Prescriber Report provides a printable log of all Rx authorized by a doctor.

This report generates a summary of all prescriptions authorized by a doctor:

- 1) Select the desired doctor from the drop-down list for this location.
- 2) Select a date range for the report by clicking on the calendar days. For a one-day report, click the same day on both calendars.
- 3) For sequential reports, note the date of last report. Use this date to generate a new report using the ending date of the previous report as a start date.
- 4) Click the [Printer Friendly](#) link and use browser buttons to print

Patient Details Page

Summary

The **Patient Details** page displays the selected patient's general information, address, mailing address, contact information, insurance information, etc and allows updating in some configurations. An insurance plan must be entered for formulary coverage information to appear with drug selections. Note the dropdown specifically for Medicare Part D. On the left-hand side of the page below the patient's name, the [RxHub/RxHistory](#) link may appear. Click to view an all- doctor Rx history from the healthplan.

All users will access the **Patient Details** page from the Navigation Bar to enter any needed information. You can come back to this page at any time to modify a patient's information.

Note for Partner users: You will see much of the information already filled in and “read-only.” Some items such as patient language or pharmacy choice will still be changeable.

After a patient has been selected or added, you may enter patient-specific information here. Those users who have Formulary access may choose the patient's Health plan from the drop down box located under the **General Patient Information** heading. Listed in this drop down box are all health plans which have been previously selected for your Account. If the patient's health plan is **not listed** you may proceed to the Admin Page and select the [Account Healthplan List](#) link. Any health plan added to this list will be available for all users to access.

The **Pharmacy** section indicates the patient's pharmacies. The **Patient Information** section stores the patient demographics. **Please note that all fields indicated with an asterisk (*) are required fields.**

Insurance/Formulary information is not required for each patient. However, if you wish to utilize the NewCrop *Formulary* feature, the health plan information must be entered on this screen. Choose from the drop-down list for your account. Formularies are more specific than the insurance coverage. Therefore, you may see multiple choices for each health plan. For instance, Blue Cross may provide more than one formulary (i.e. PPO vs. HMO). In addition, coverage may differ by employer. You must closely inspect the list of alternative formularies to find the one matching your patient's coverage as listed on their card or benefit information. If you can't find a match, speak with your Account Manager.

This patient's previously selected pharmacies and entered allergies are also displayed at the top of the page.

If you make any changes or additions to this page, be sure to click the **<Save>** button to record the updates.

DOQ-IT by request

DoctorR

17;s Office Quality-Information Technology is a new quality improvement program sponsored by Medicare. It may evolve into “pay-for-performance.” Go-live is

scheduled for Fall of 2005. In the meantime, the account can monitor practice quality measures such as percent of coronary artery patients receiving aspirin.

Participation is optional for NewCrop accounts. Your account manager can activate this feature.

</SPAN

Medicare PartD-O-Lizer

Summary

The **Medicare PartD-O-Lizer** displays choices available to the patient and a summary of drug coverage.

Coming very soon!!!!

Medication Entry and Refill Page

Summary

The **Medication Entry and Refill Page** is used to 1) quickly record medications for new patients or those prescribed by doctors outside your account. These medications are added to the patient record and can be selected for modification and re-use on the Compose Rx page. 2) add an Rx request to Pending Rx for further processing by doctor or clinical staff.

The **Medication Entry and Refill Page** may be accessed by clinical users via the link on the **Compose Rx Page** or the link on the **Admin Functions** page. This page allows staff not authorized to finalize prescriptions to still enter medication information into the patient record for reference or future processing.

For **new patients**, use this page to enter medications initially. You search for a drug the same as you would on the Compose Rx page however you will notice that, once

selected, the checkbox to the left of the drug name is highlighted in blue and a complete sig is not required. Drug review does not occur when adding an Rx on this page, however the **Drug Review** can be used to perform this function after entry. Any doctor's name can be entered as the prescriber and any start date can be entered. Be sure to enter that information prior to searching for and selecting the drug. The medications entered on this screen can later be selected on the Compose Rx Page for a refill or to change a sig and are included in drug interaction review. **Note:** Be sure and select the drug first. Not doing so will cause the other information to be re-entered.

You are able to place an entered medication on the patient's current medication list for viewing by the doctor. To do this, select the checkbox to the left of the entered medication and click **<Add to Current Medications>** (Note, it will not have a **ReWrite** box because it cannot be renewed.) Detail will not show either print or transmit information since neither has occurred.

If you do not add the medication to the patient's current medication list, it will appear on the Compose Rx page as a pending medication. You can enter the **Detail Rx Page** by clicking on the magnifying glass icon to add a message if needed, or to assign a **DR** or **NS** for the next step in processing of refills. A complete sig is not required at this point. Click **<Save>** and the Rx will display on the Pending list of the Compose Rx page.

In addition to adding medications, you may also enter **Allergies** from this page.

Patient Face Sheet

Summary

The Patient Version uses a non-medical sig and displays additional educational materials (from Rx Detail.)

The Patient Face Sheet feature provides a summary of the patient's medications, allergies, diagnoses and demographics in a printable format. You may access this screen from the **<Pt. Face Sheet>** on the Compose Rx page. The patient's

medication list is also listed. This list replaces terms such as “tid” with “three times a day,” etc. for easier patient understanding.

To print this page choose <File>, <Print> and then select your desired actions on the use of the work-flow and reporting functions of NewCrop Electronic Prescribing follow. This information also appears at the bottom of each page via the Help Screens. A summary is included in “How to Write a Prescription.”

Maintain Pharmacy List

Summary

Maintain Pharmacies shows each location’s list of selected pharmacies. It can be built from here or allowed to accumulate as selected for each patient. Rarely used pharmacies can be deleted.

Use this page to add pharmacies to the Location list, edit incorrect fax numbers, and delete seldom used pharmacies. You may reach this page by clicking on the link **<to add a pharmacy click here>** from the Transmit Page, or you may access this page from the Administrative Functions page.

The Location pharmacy list is automatically generated as pharmacies are selected for patients on the Transmit Page. You may also choose to add pharmacies from the Admin Page at set-up, to provide a starting selection list.

Search by for a new pharmacy by zip code, city, phone, name, or state. (Add a state for common names such as Riverside.) Note that a pharmacy name must be entered exactly. If you are not sure of spelling, use part of the name and add a street, if known.

To edit or add a fax number, click on the desired pharmacy, change the number and then click **<Save>**. To remove pharmacies, check the boxes on the left and click **<Delete>**.

Account Healthplan/Formulary List Page

Summary

Use the [Account Healthplan List](#) link to build and maintain your list of insurance and formularies. The list becomes a “pick-list” for each patient.

This page allows selection of the insurance plan formulary used by your account's patients. *If the account has the Medi-Media Formulary feature*, coverage status for each drug will be displayed, specific to the patient's insurance coverage. To accomplish this, healthplans must be listed for the account and then assigned to each patient.

(If NewCrop is electronically linked with another application in the office such as practice management or patient record, healthplans may be selected there as part of the patient set-up process.)

Once selected, the account's healthplans and associated formularies are displayed as a drop-down list for each patient on the Patient Detail pages.

Formularies

Formularies are more specific than the insurance coverage. For instance, Blue Cross may provide a different formulary with each plan (i.e. PPO vrs. HMO.) In addition, coverage may differ by employer. Therefore, you must closely inspect the list of alternative formularies to find the one matching your patient's coverage as listed on their card or benefit information. One bit of good news: preferred drugs will generally be the same across formularies for a given healthplan. (Unfortunately, there is no formulary index system. The group number may be of some help. Be sure and enter this as part of patient demographics.) Contact employer benefit managers for additional information.

Medicare formularies are now included: Part D. Handle these as you would an insurance plan formulary.

Building Your Account's Healthplan/Formulary List

To build your account list, start by clicking the [add additional healthplans](#) link. You will see all healthplans / formularies that include your state name. Use the "Add" check boxes to the left of the healthplan / formulary name to select the ones you want and then click the **<Add to List>** button to start building your account list.

Next, use the Search box to find additional choices. Large employers may be listed nationally and do not appear by state: search the employer name. There are also national healthplans and Medicare formularies that do not appear by state: search the plan's name.

Unable to Find a Healthplan?

If you cannot find the desired plan, try a different or shorter version of the name. Contact customersupport@newcroprx.com with the missing plan. Medimedia currently provides information for 3400 plans nationally and will endeavor to add any missing ones.

Patient Notes Page

The **Patient Notes** page provides a means of entering and storing patient information. To reach this page, select a patient on the Patient Select page and click **<Pt Notes>** on the Navigation Bar.

To write a note, type in any information you choose. There is no set format. Your name and date/time of entry are automatically added to the note.

Each note is added to the Patient Notes list with the most recent appearing first. No changes are possible once a note is **<Saved>**. Correct any error by writing a second note.

Patient Diagnosis Page

The **Patient Diagnosis** page displays diagnoses and past medical history. To add a diagnosis to the patient's **Current Diagnosis List** either select a diagnosis from the list displayed by clicking on the ICD9 code or enter at least the first three characters of the diagnosis and click **<Search>**. If you know the ICD9 code, you may enter it into the search box.

The search results will display below the search box. Click on the appropriate ICD9 code to select it. Doing so returns you to the Patient Diagnosis page with the selected ICD9 code and description entered in the appropriate boxes. You may then move down to the **Date of Onset** field. This field is pre-populated with the current date. You click on the box and overwrite today's date. If the exact date is not known or necessary, click on the **Check box if exact date not known** box.

In the **Treating Physician** box, the current doctor's name can be overwritten by clicking in the box and overwriting it with the appropriate physician's name.

NOTE: If the code you are searching for is not displayed, then you should change your search criteria and click **<Search>** again.

Once you have filled in the fields, click the **<Save>** button. This will add the diagnosis to the patient's list of current diagnoses. If you have finished searching for the diagnoses, you can click the **<Close List>** button which will display the patient's current diagnoses list and **Previous Diagnosis List**.

To move a current diagnosis to a prior diagnosis check the Move box associated with the chosen diagnosis and then click the **<Move to Prior Dx>** button. You may choose to move more than one at a time by selecting more than one checkbox.

Similarly, to move a previous diagnosis to the current diagnosis list, check the Move box associated with the chosen diagnosis and then click the **<Move to Current Dx>**. You may choose to move more than one at a time by selecting more than one checkbox.

In addition, you may type any Medical History for this patient in the **Past Medical History** text box by clicking in the white box and typing any desired information. Then click **<Save Notes>** to record the information. Any information entered and saved here will be displayed on the Face Sheet or Patient's Face Sheet which can be printed from the **<Admin>** page or from the **Compose Rx** page.

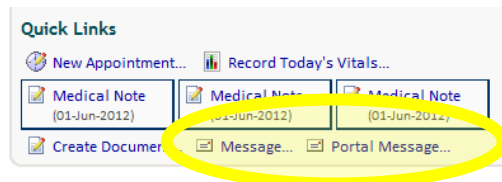
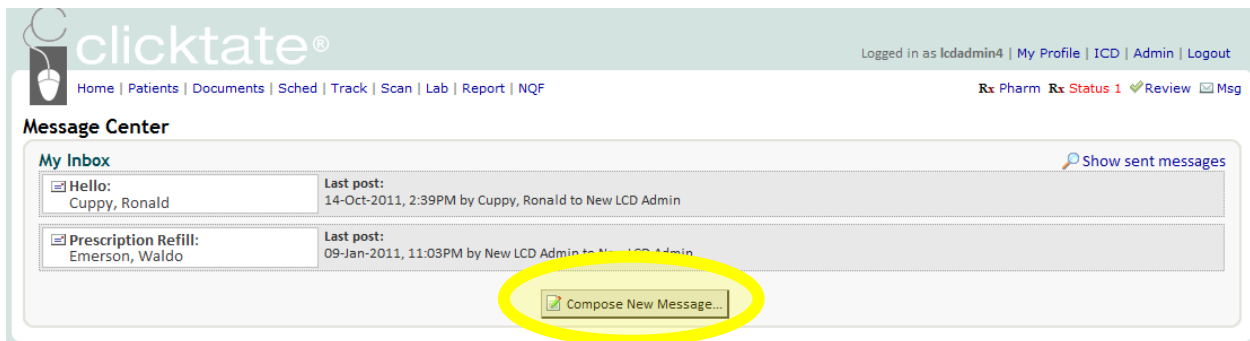
To print from the Admin page, click on the **<Admin>** tab. Under the Patients section, click on the [Face Sheet / Patient Face Sheet](#) link which takes you to the **Patient Face Sheet** page. Your patient's name will already be displayed. From here you can select the Face Sheet or Patient Face Sheet checkbox depending upon which format you want to print. Clicking the [Printer Friendly](#) link displays the Face Sheet in a new window. Choose **<Print>** from the Windows File menu to send the sheet to your network printer. Click on the **<X>** in the upper right hand corner of the new window to close the window and return to the Print Patient Face Sheet.

To return to the Patient Diagnosis page click **<Patient Diagnosis>** on the Navigation bar. If you are done, click on any tab of the Navigation bar to go to another function or start another task.

Section XI: Messaging

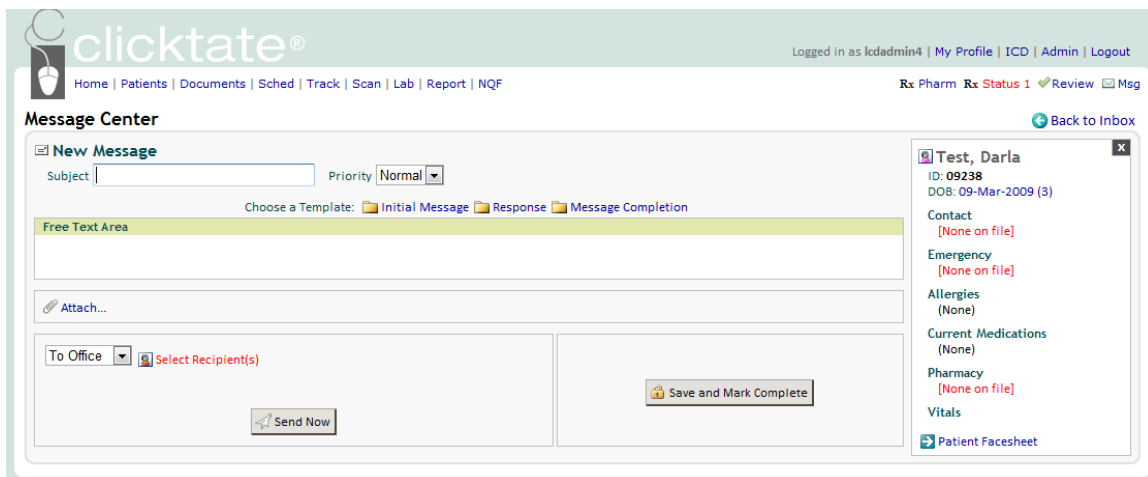
Clicktate offers a robust messaging system which allows messages to be sent within the office as well as to patients via the patient portal. The messaging system is accessed from:

- A specific patient Facesheet in the Quick Links Section
- The Navigation menu found at the top of most pages in Clicktate followed by the “Compose New Message...” button



After a new message is created, the Message center will appear and will allow the message to be created.

The Messaging system works in a manner similar to most email messaging systems. Messages may be sent to one or multiple recipients, may be marked routine or stat and may have attachments included.



One or more templates may be chosen or the message may be entered via free text.

- If a template is utilized, the subject heading will be auto completed.
- Any document in the patient's chart may be attached to the message.
- Messages will be date and time stamped and will remain in the patient's chart.

Once a message is completed and is ready to be recorded in the patient chart, choose the "Save and Mark Complete" button. The message will be closed and recorded in the patient chart.

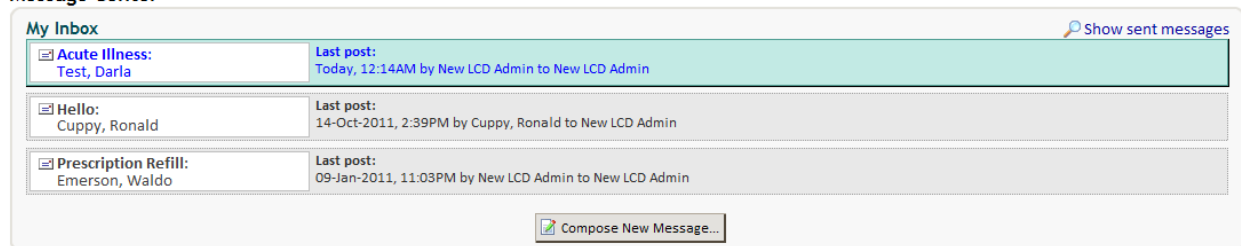
A quick note may also be recorded using the Message system and immediately choosing the "Save and Mark Complete" button without sending the message to a recipient.

When messages need to be reviewed, the "Msg" tab at the top right of the screen will turn red and indicate the number of messages to review.



Selecting the Message option will open the message center.

Message Center



Unread messages will appear in green. Messages that are read but not completed/ acted on will appear in grey. To view a history of all sent messages, select "Show sent messages".

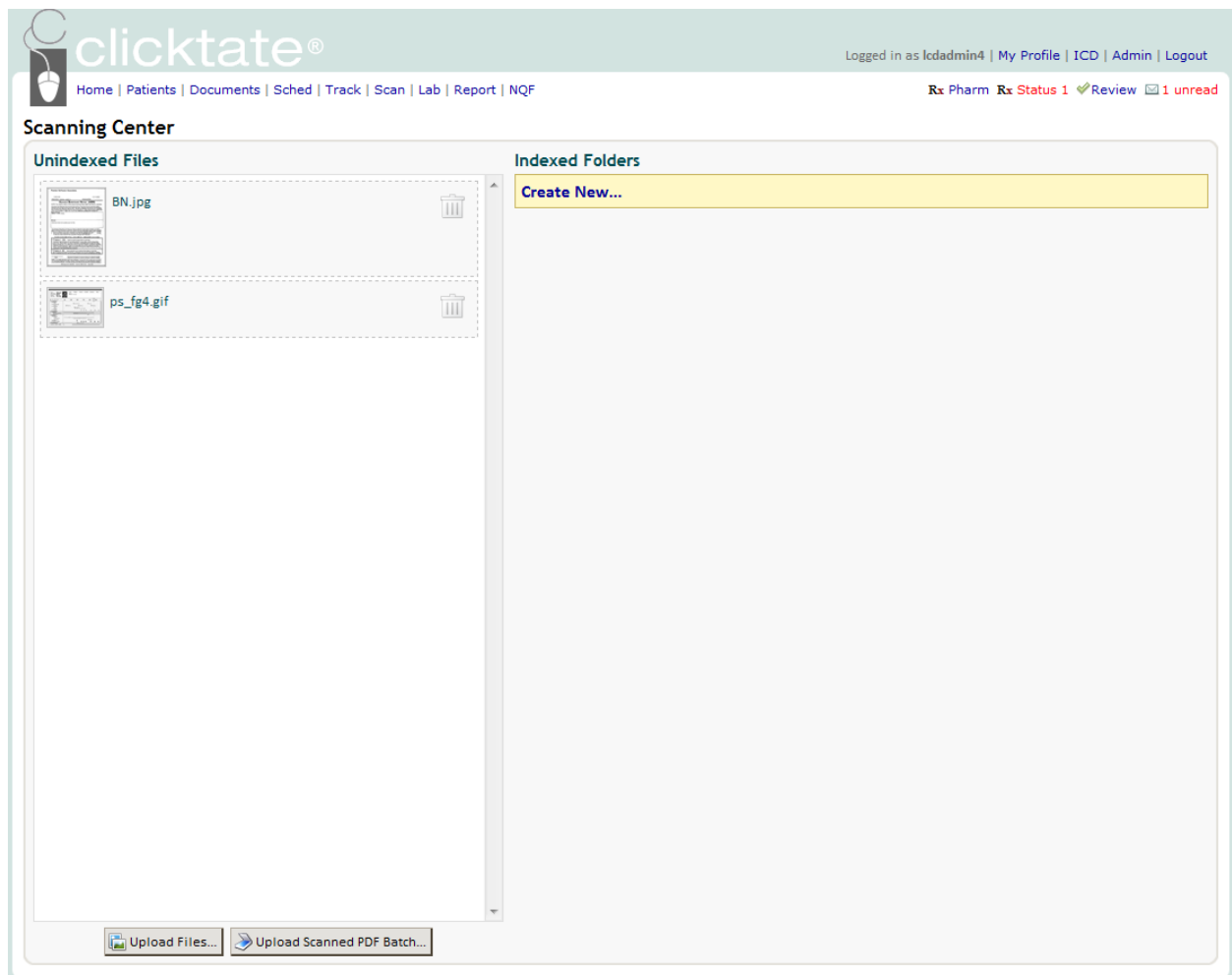
Section XII: Scanning

The scanning center allows the input of scanned documents into the patient chart. It allows employs a “closed loop” ordering function that easily allows scanned documents to be reconciled with orders.

The scanning center is accessed from the top navigation menu.



Selecting “Scan” opens the scanning center.



The scanning center has unindexed files on the left side of the screen and files which have been indexed to a patients chart on the right side of the screen.

Any scanner may be used with the scanning system.

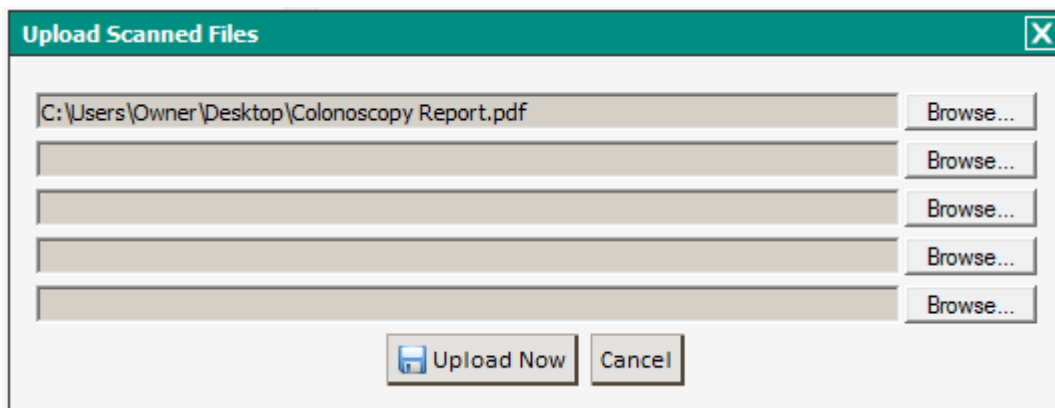
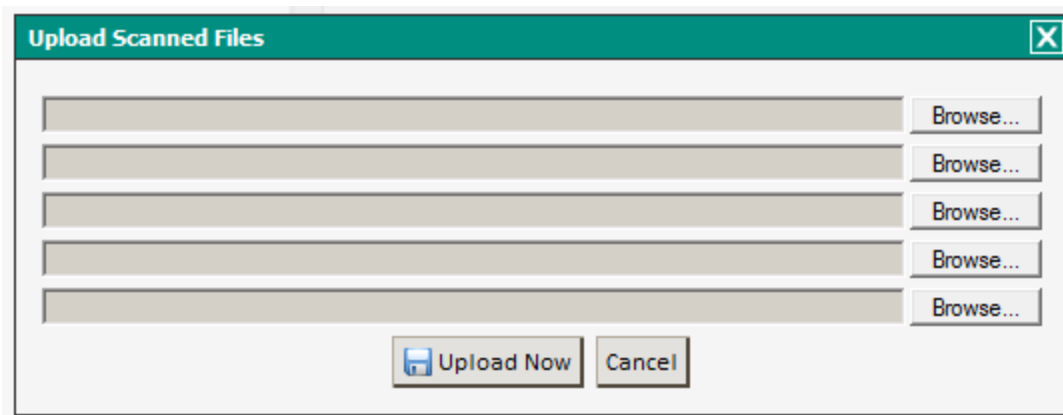
To upload files into Clicktate:

Upload the files to your computer using your scanner.

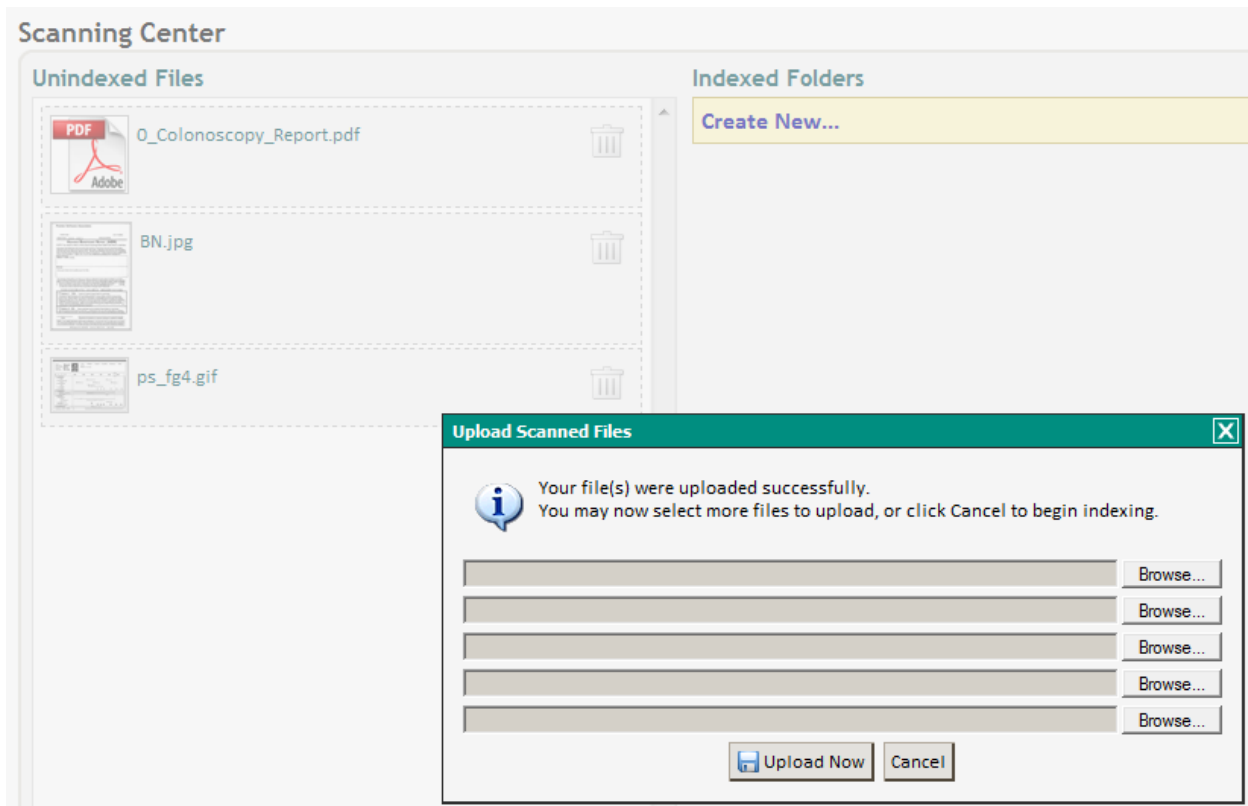
Files should only be uploaded to a secure, password protected computer. In addition, we recommend using a “Data Shredding” or “Document Hardwipe” program to delete the files from individual computers once the files are uploaded to the secure Clicktate servers.

After the files are uploaded to the computer, they may be selected from the desktop.

- Use the “Upload Files...” option to upload a file for a single patient
- Use the “Upload Scanned PDF Batch...” to upload a file containing documents related to multiple patients



Selecting “Upload Now” will move the selected file into the unindexed files area of the scanning center.



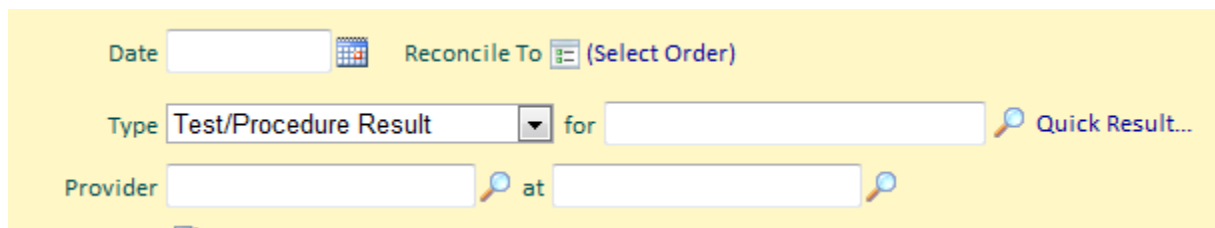
Selecting a file from the unindexed files will move the file to the indexed folder and open the indexing box.

The screenshot shows the 'Indexed Folders' interface. At the top, there is a '(Select Patient)' button and a 'To' dropdown menu set to 'New LCD Admin', followed by a 'Reviewed' checkbox. Below these are several form fields: 'Date' with a calendar icon, 'Reconcile To' with a list icon and '(Select Order)' text, 'Type' with a dropdown arrow, 'Provider' with a search icon, 'at' with a search icon, and 'Area' with a map icon and '(Select)' text. At the bottom, a green bar displays the file 'O_Colonoscopy_Report.pdf' with a PDF icon, and three action icons: an up arrow, a down arrow, and a close 'X' icon.

From this area, the file may be indexed to the patient, date, type, provider and area. Marking the “Reviewed” box indicates that the document has already been reviewed by a provider and the document will therefore NOT go to the document review section for that provider. Leaving the “Reviewed” button unchecked will send the document to be reviewed.

A provider index may be built by selecting the magnifying glass beside the Provider section. This may be built as documents are entered. Practices will find that their individual provider directory builds quickly as they enter documents.

Any document that is entered as a Test/Procedure will require that the procedure type be entered.

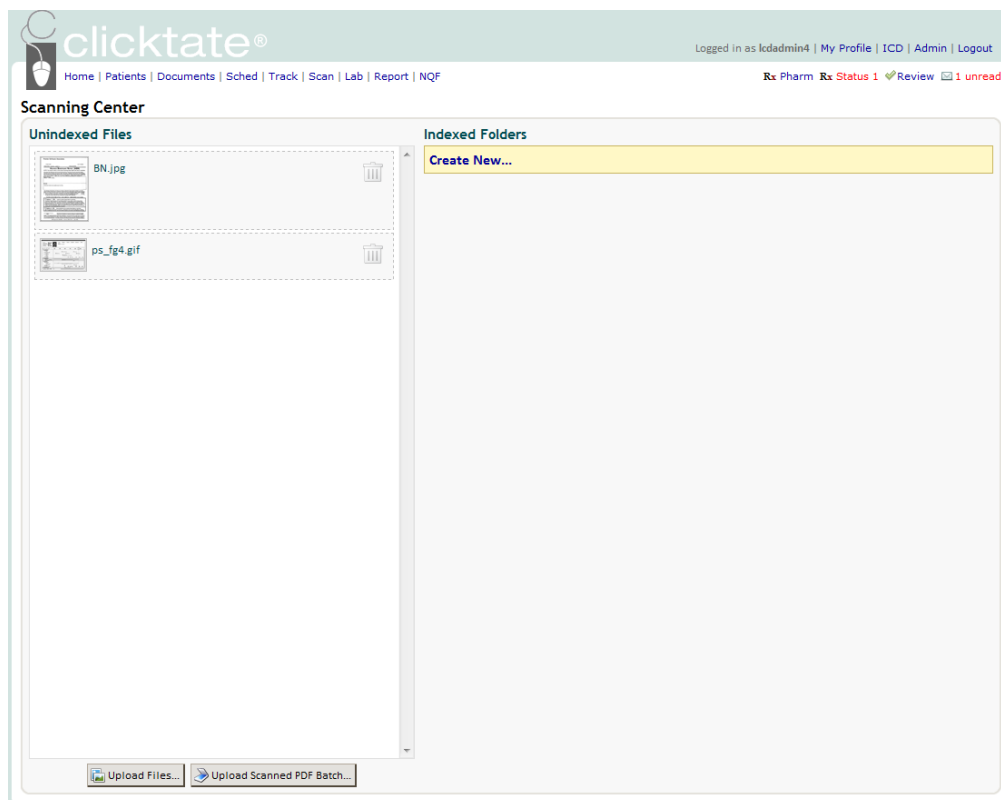


The screenshot shows a document entry form with a yellow background. It includes a 'Date' field with a calendar icon, a 'Reconcile To' dropdown menu with a list icon and the text '(Select Order)', a 'Type' dropdown menu currently showing 'Test/Procedure Result', a 'Provider' field, and search icons (magnifying glasses) for the 'Reconcile To', 'Type', and 'Provider' fields. There is also a 'Quick Result...' link with a magnifying glass icon.

Typing the procedure type will open a menu containing possible procedures. A quick result and notes may also be added by using the “Quick Result...” link.

Selecting “Reconcile To”, will open all outstanding orders currently pending for a patient, allowing the result to be reconciled to an order. The order will subsequently be automatically marked complete and closed. The “Reconcile To” option is only available for patients who have outstanding orders.

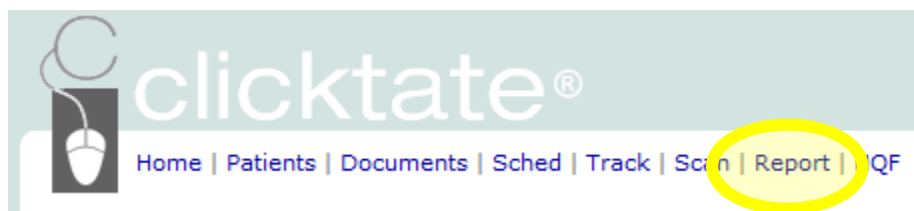
Documents for multiple patients may also be scanned and input into the system in bulk by using the upload scanned PDF batch option. The system will divide the document into individual pages for indexing. To index a batch file, select all pages that are part of a document and enter them into the appropriate chart.



Section XIII: Reporting

Clicktate has a robust and easy to utilize reporting system. Reports may be generated across multiple parameters, across varied date ranges and for one or multiple providers.

To access the reporting system select the “Report” tab in the top menu bar.



From the reporting page, a report type may be selected.

Reporting



- Audit Logs are Audits of System Use within Clicktate.
- Clinical Decision Support reports are reports that are based on Clinical Decision support rules and appear on appropriate patients’ facesheets as clinical reminders. Clicktate includes a preconfigured set of Clinical Decision Support rules. The preconfigured reports cannot be altered at the user level. Users may also create their own practice specific Clinical Decision Support Rules.
- Meaningful Use reports are reports that generate meaningful use data.
- Patient reports are reports that can be used to quickly gather data regarding your patient population

To generate a report, select the report from the list and it will automatically run and generate the report based on the report characteristics.

Reporting

New LCD Admin - LCD Solutions, LLC - LCD Headquarters Lexington, KY 40536

NQF 0013

[Configure this report](#) [Return to list](#)

Hypertension: Blood Pressure Measurement: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure recorded.

Patients (AGE at least "18")

- having at least one of Diagnoses (ICD CODE contains "401" and ACTIVE is "Yes", ICD CODE contains "997.1" and ACTIVE is "Yes", ICD CODE contains "405" and ACTIVE is "Yes")
- having Vitals (SYSTOLIC has a value and DIASTOLIC has a value)
- having at least 1 Sessions (TEMPLATE is "Medical Note")

Patients (AGE at least "18")

- having at least one of Diagnoses (ICD CODE contains "401", ICD CODE contains "997.1", ICD CODE contains "405")
- having at least 1 Sessions (TEMPLATE is "Medical Note")

Patients	Diagnoses	Vitals	Sessions
Biltmore, Troy	Essential hypertension: Unspecified (401.9)	01/11/11: Pulse: 64, Resp: 20, BP: 140/52 RUE, Temp: 97.8, Wt: 155, Height: 69, BMI: 23	Medical Note
Cuppy, Ronald	Essential hypertension: Benign (401.1)	12/26/09: Pulse: 82, Resp: 12, BP: 128/82 LUE, Temp: 99, Wt: 132, Height: 66, O2: 94 Room Air, BMI: 21	Medical Note
Rogers, Tim	(405)	12/24/09: Pulse: 80, Resp: 12, BP: 134/74 RUE, Temp: 98.9, Wt: 156, Height: 72, BMI: 21	Medical Note

Numerator record(s) returned: 4 [Download](#)

[Show Denominator \(6 records\)](#)

Total: 66.67%

The report parameters are displayed on the report. If a "Configure this report" link is present on the top of the page, the report may be altered by the user.

Creating a New Report

To create a new report, select "New Report..." located at the bottom of the Reporting page.

Reporting

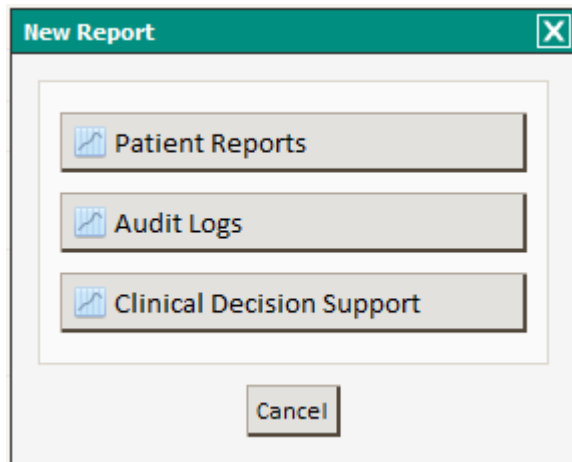
Type

- ☒ (All)
- [Audit Logs](#)
- [Clinical Decision Support](#)
- [Meaningful Use](#)
- [Patient Reports](#)

Name	Description
A1C with Zip	
Cholesterol for Hyperlipidemia	Cholesterol Check every year for those
HG	
HIV Disease	Patients diagnoses with HIV or AIDS
Lipitor	
NQF 0013	Hypertension: Blood Pressure Measurement: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure recorded.
NQF 0024	Weight Assessment and Counseling: Percentage of patient visits for patients aged 18 years and older who had an outpatient visit with percentile documentation, counseling measurement year,
NQF 0027	Tobacco Use Cessation: The percentage of smokers or tobacco users, who were received advice to quit smoking or tobacco use cessation measurement year,
NQF 0028	Preventive Care and Screening Measurement: Percentage of patient visits for patients aged 18 years and older who have been seen for at least 2 of within 24 months.

[+ New Report...](#)

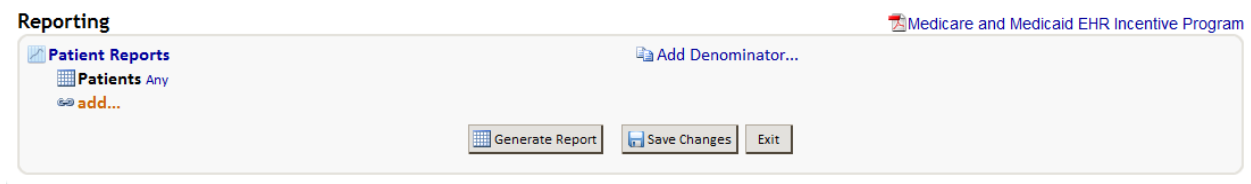
Next, select the report type.



The "New Report" dialog box has a teal header with a close button (X). It contains three stacked buttons: "Patient Reports", "Audit Logs", and "Clinical Decision Support", each with a small blue icon to its left. A "Cancel" button is located at the bottom center.

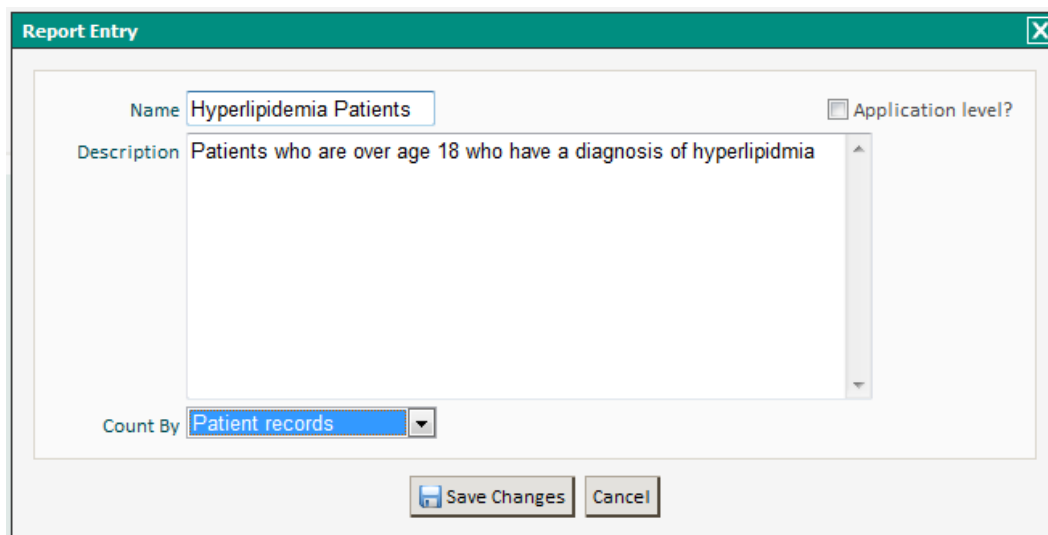
Creating a Patient Report

To create a patient report, select "Patient Reports" from the New Report pop-up. A blank patient report page will appear.



The "Reporting" toolbar features a teal header. On the left, it shows "Patient Reports" with a blue icon, "Patients Any" with a grid icon, and "add..." with a plus icon. On the right, there is a link "Add Denominator...". At the bottom right, there are three buttons: "Generate Report", "Save Changes", and "Exit". A "Medicare and Medicaid EHR Incentive Program" logo is in the top right corner.

All new reports have the default name "Patient Reports". To change the report name, select "Patient Reports" and enter and save the name of the new report. A description may also be entered.



The "Report Entry" dialog box has a teal header with a close button (X). It contains a "Name" field with the text "Hyperlipidemia Patients" and a "Description" text area with the text "Patients who are over age 18 who have a diagnosis of hyperlipidmia". There is a checkbox labeled "Application level?". At the bottom left, there is a "Count By" dropdown menu currently set to "Patient records". At the bottom right, there are "Save Changes" and "Cancel" buttons.

Reporting

Medicare and Medicaid EHR Incentive Program

Hyperlipidemia Patients

Add Denominator...

Patients Any

add...

Generate Report

Save Changes

Delete Report

Exit

Do define the patient criteria, select and modify “Any” beside the patient link.

Patients Criteria

Patient ID

Last Name

First Name

Sex

Age

Birth Date

Deceased

Race

Ethnicity

Language

Living Will

POA

User Prompted

OK Cancel

The report may be narrowed to any patient criteria found in the pop-up fields.

Patients Criteria

Patient ID

Last Name

First Name

Sex

✓ Age

Birth Date

✓ Deceased

Race

Ethnicity

Language

Living Will

POA

User Prompted

OK Cancel

To add additional criteria to the report, select the “add...” option.

Reporting Medicare and Medicaid EHR Incentive Program

Hyperlipidemia Patients Add Denominator...

Patients AGE at least "18" and DECEASED is empty

add...

Generate Report Save Changes Delete Report Exit

The Add Criteria Group pop-up will appear. Additional criteria may be added for Address, Diagnoses, Medications, Medication History, Allergies, Procedures, Results, Tobacco Usage, Immunization Status, Vital Sign Parameters, Documents, and Encounters (Office Visits).

Add Criteria Group

Patients	Address	Diagnoses	Medications
Med History	Allergies	Procedures	Results
Social: Tobacco	Immunizations	Vitals	Documents
Encounter			

To add a diagnosis, select the "Diagnoses" option. The selected criteria will be added to the report.

Reporting

Hyperlipidemia Patients

Patients AGE at least "18" and DECEASED is empty

having

Diagnoses Any

Another...

add...

Selecting "Any" from the diagnosis category will allow further drilling down to more specific criteria.

Diagnoses Criteria

ICD Code

Description

Date

Date Closed

Active

Status

User Prompted

OK Delete Cancel

Each category will have multiple criteria from which specific data may be chosen. Not all fields are necessary. Add data only to those fields which are appropriate for the desired report. Under “Diagnoses” the Description category allows searching for a verbal diagnosis, whereas ICD code searches for an ICD coded diagnosis. Multiple criteria may be added to the same report.

To add Hyperlipidemia, Hypertriglyceridemia and the ICD code 272.4, first add Hyperlipidemia under Description. We recommend using the “Contains” option as it allows broader searches.

The screenshot shows a dialog box titled "Diagnoses Criteria". It has several input fields: "ICD Code", "Description", "Date", "Date Closed", "Active", and "Status". The "Description" field is currently set to "contains" and "hyperlipidemia". There are also "OK", "Delete", and "Cancel" buttons at the bottom. A "User Prompted" checkbox is also visible.

Reporting

The screenshot shows a report builder interface for "Hyperlipidemia Patients". It displays a criteria chain: "Patients AGE at least '18' and DECEASED is empty" followed by "having" and "Diagnoses DESCRIPTION contains 'hyperlipidemia'". There is an "add..." button and a "Gen" button.

Next choose “Another...” to add additional criteria.

Reporting

The screenshot shows the same report builder interface, but now it includes an additional criteria step. The chain is: "Patients AGE at least '18' and DECEASED is empty" followed by "having all of" and two "Diagnoses" criteria: "DESCRIPTION contains 'hyperlipidemia'" and "Any". There is an "add..." button and a "Gen" button.

Choose “Any” again to add additional criteria. Add the additional criteria as already stated.

Reporting

Hyperlipidemia Patients

Patients AGE at least "18" and DECEASED is empty

having all of

- Diagnoses** DESCRIPTION contains "hyperlipidemia"
- Diagnoses** DESCRIPTION contains "hypertriglyceridemia"
- Diagnoses** ICD CODE contains "272.4"

Another...

add...

Generate

Once all criteria are entered, choose the Join Criteria, here defaulted to “having all of” to change the options and indicate the join parameters.

Criteria Group Type

having at least one of having all of not having any of

not having all of

Delete

In this example, we’ll change the Criteria Group Join Parameter to “having at least one of”.

Hyperlipidemia Patients

Patients AGE at least "18" and DECEASED is empty

having at least one of

- Diagnoses** DESCRIPTION contains "hyperlipidemia"
- Diagnoses** DESCRIPTION contains "hypertriglyceridemia"
- Diagnoses** ICD CODE contains "272.4"

Another...

add...

Generate Report **Save Changes** **Delete Report** **Exit**

At this point, the report may be saved or generated to view the data. Selecting “Generate Report” will render the report. It is recommended that the report be saved prior to running a report.

Hyperlipidemia Patients

Patients AGE at least "18" and DECEASED is empty

having at least one of

- Diagnoses** DESCRIPTION contains "hyperlipidemia"
- Diagnoses** DESCRIPTION contains "hypertriglyceridemia"
- Diagnoses** ICD CODE contains "272.4"

Another...

add...

Generate Report **Save Changes** **Delete Report** **Exit**

Patients	Diagnoses
Barnaby, Jonas	Hyperlipidemia (272.4)
Bear, Pooh	Hyperlipidemia (272.2)
Biltmore, Troy	Disorders of lipid metabolism: Other and unspecified hyperlipidemia (272.4)
Bower, Mandy	Hyperlipidemia (272.2)
Cuppy, Ronald	Disorders of lipid metabolism: Mixed hyperlipidemia (272.2)
Demo, Khani	Hyperlipidemia (272.2)
Emerson, Waldo	Hyperlipidemia (272.2)
Fife, Barney	Hyperlipidemia (272.2)
Frances, Frank	Hyperlipidemia (272.2)
Henthorne, Millie	Hyperlipidemia (272.2)

Numerator record(s) returned: 30 **Download**

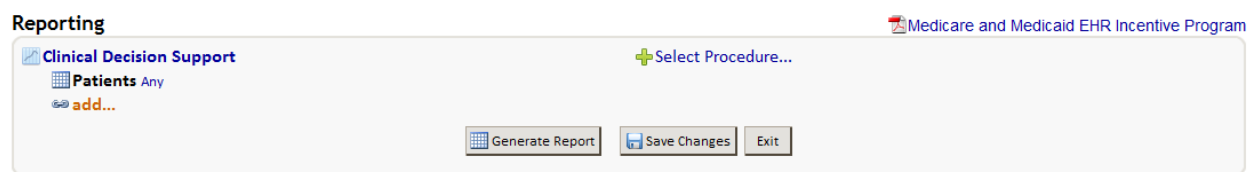
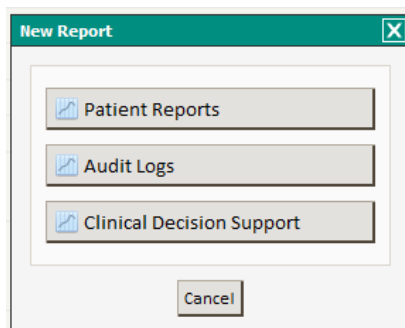
To add a denominator and generate a percent calculation, select “Add Denominator...” and enter the criteria as above. The criteria from the Numerator will be copied into the denominator fields.

Creating a Clinical Decision Support Report

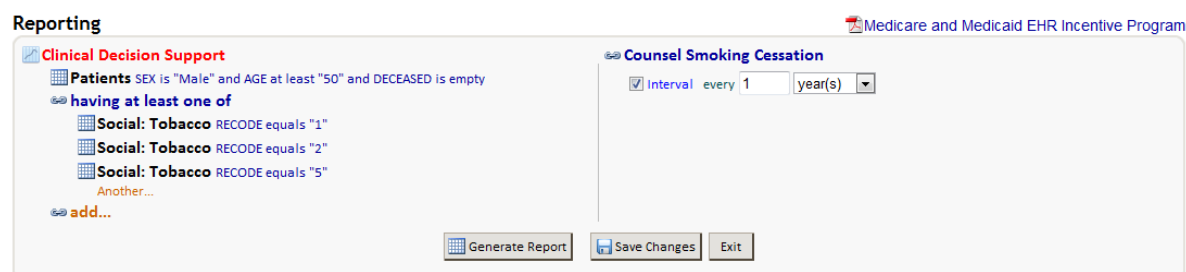
Clinical decision support reports are reports that will generate clinical reminders on the patient facesheet. Examples might include:

- All patients over a certain age who are due for a certain test
- All patients with a specific diagnosis who need to be on a certain medication
- All patients who meet specified clinical criteria who are due for a certain immunization

To generate a Clinical Decision Support report, select Clinical Decision Support from the “New Report...” option.



Add the PATIENT CRITERIA on the left criteria area of the report builder. IT IS NOT NECESSARY TO THE ADD THE TEST THAT IS DUE OF THE INTERVAL. THESE ARE ADDED UNDER THE “Select Procedure...” AREA OF THE REPORT. A report to generate reminders for all male patients who are over age 50 who have a diagnosis of tobacco abuse who haven’t add counseling for smoking cessation is shown below.



The report may be named as desired by selecting the “Clinical Decision Support” option.

Section XIV: The Visit Summary

A visit summary may be generated to provide the patient at the completion of each visit. The visit summary is generated from data entered into the clinical encounter note. The visit summary includes:

- Diagnoses from the current visit
- Vital Signs from the current visit
- Laboratory and Radiology study results (if available and documented into the note)
- Patient instructions in patient friendly language
- Outstanding orders
- Documented Medication Allergies
- Medication Changes
- The current medication list

The visit summary may be generated from the patient console or from the patient facesheet. It is recommended that the visit summary be generated after the lab orders are generated. The visit summary may be generated either before the note is signed or at the conclusion of the visit, after the note is signed and locked. The visit summary is saved under the Clinical Data and Documentation section of the chart.

To generate a visit summary, after the note is completed, select Visit Summary from the top menu bar.

File Edit Help Admin

Save As Sign/Lock Orders Visit Summary Download Clipboard Clear Undo Delete Freetext Exit Console

Template Map Customize

Search...

Runner, Road - Medical Note - Sunday, 26-Aug-2012

Send To: [None]

Laboratory Data

Lipid Profile				
DATE	Chol	HDL	LDL	Trig
08/26/2012	200	50	100	150
Norms	< 200	>55	<100	<150

Urinalysis 08/26/2012 : Color- yellow . SpGr- 1.010 . pH- 5.0 . Leukocyte Este
Urobilinogen- normal . Bilirubin- negative . Blood- negative .

Impression and Assessment

Hypertension . (997.91)

Hyperlipidemia . (272.2)

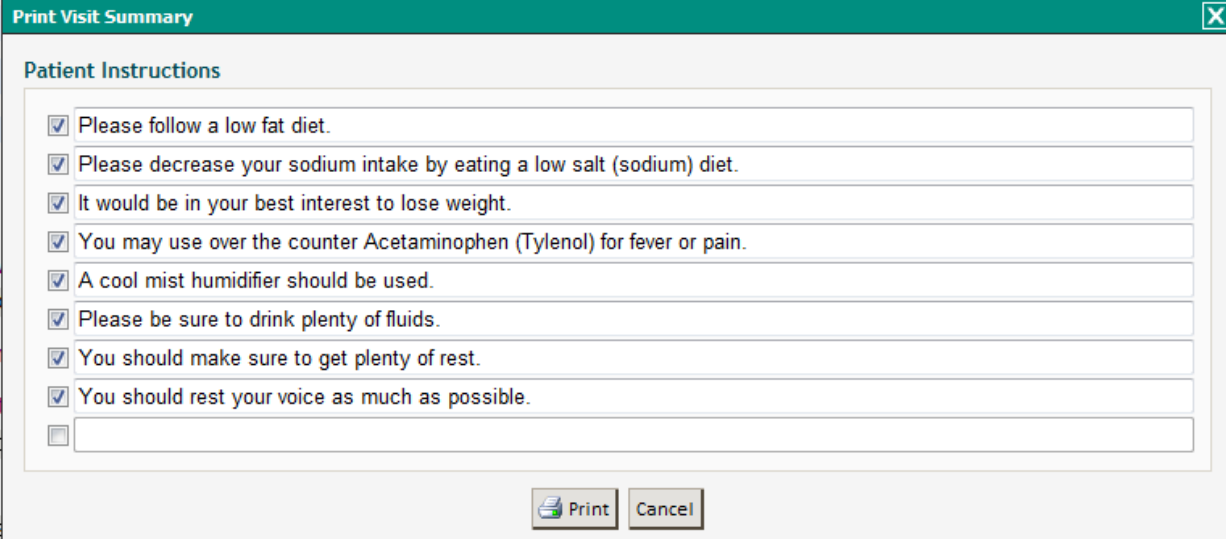
Upper Respiratory Infection . (465.9)

Plan

Hypertension Plan: He was instructed to eat a low fat diet. Instructions were given to eat a l
SHOW EDUCATION RESOURCES

Hyperlipidemia Plan: The current plan was continued. DELETE ORDERS The following tests w

The patient instruction pop-up will appear. This is generated from data entered into the patient note. Additional patient instructions may be added, or instructions may be deselected.




The image shows a software window titled "Print Visit Summary" with a close button (X) in the top right corner. Below the title bar, the section "Patient Instructions" is displayed. It contains a list of eight instructions, each preceded by a checked checkbox. The instructions are: "Please follow a low fat diet.", "Please decrease your sodium intake by eating a low salt (sodium) diet.", "It would be in your best interest to lose weight.", "You may use over the counter Acetaminophen (Tylenol) for fever or pain.", "A cool mist humidifier should be used.", "Please be sure to drink plenty of fluids.", "You should make sure to get plenty of rest.", and "You should rest your voice as much as possible." Below these instructions is an empty checkbox followed by an empty text input field. At the bottom of the window, there are two buttons: "Print" (with a printer icon) and "Cancel".

Print Visit Summary

Patient Instructions

- ☒ Please follow a low fat diet.
- ☒ Please decrease your sodium intake by eating a low salt (sodium) diet.
- ☒ It would be in your best interest to lose weight.
- ☒ You may use over the counter Acetaminophen (Tylenol) for fever or pain.
- ☒ A cool mist humidifier should be used.
- ☒ Please be sure to drink plenty of fluids.
- ☒ You should make sure to get plenty of rest.
- ☒ You should rest your voice as much as possible.
- ☐

 Print Cancel

Select "Print" to generate the visit summary.

Vital Signs

- Pulse: 56 Beats Per Minute
- Respiratory Rate: 10 Breaths Per Minute
- Blood Pressure: 124 (Systolic) / 62 (Diastolic)
- Temperature: 97.0 F

Today's Diagnoses

- Hypertension
- Hyperlipidemia
- Upper Respiratory Infection

Allergies

- No Known Drug Allergies

Today's Results

• Laboratory Data

Lipid Profile				
DATE	Chol	HDL	LDL	Trig
08/26/2012	200	50	100	150
Norms	< 200	>55	<100	<150

Urinalysis 08/26/2012: Color- yellow. SpGr- 1.010. pH- 5.0. Leukocyte Esterase- negative. Nitrite- negative. Protein- negative. Glucose- normal. Ketones- negative. Urobilinogen- normal. Bilirubin- negative. Blood- negative.

Your Plan

- Please follow a low fat diet.
- Please decrease your sodium intake by eating a low salt (sodium) diet.
- It would be in your best interest to lose weight.
- You may use over the counter Acetaminophen (Tylenol) for fever or pain.
- A cool mist humidifier should be used.
- Please be sure to drink plenty of fluids.
- You should make sure to get plenty of rest.
- You should rest your voice as much as possible.

Ordered Today

- BMP
- CK-MB

- Culture Throat

Medication Changes

- Add: Zithromax 500 mg Tab (2 tablets on day 1 and 1 tablet on days 2-5)

Current Medication List

- Depotest 200 mg/mL IM Oil (1 mL every two weeks intramuscular inject)
- Lipitor 10 mg Tab (1 tablet at bedtime by mouth)
- lisinopril 10 mg Tab (1 tablet daily by mouth)
- Synthroid 100 mcg Tab (1 tablet daily by mouth)
- Toprol XL 50 mg Tab (1 tablet daily by mouth)
- Zithromax 500 mg Tab (2 tablets on day 1 and 1 tablet on days 2-5)